UHN Toronto General Toronto Western Princess Margaret Toronto Rehab

Toronto Rehab
550 University Avenue
Toronto, ON M5G 2A2

Tel: (416) 597-3422 x3065
Fax: (416) 597-7066
www.uhn.ca

Geriatric Outpatient Services – Toronto Rehab

Service	Criteria for referral
Geriatric Day Hospital	• *Outpatient rehab for patients over the age of 65 requiring two or more of the following services: nursing, physiotherapy, occupational therapy, social work, speech-language pathology, therapeutic recreation* • *Up to 10-week duration, 2 sessions/week; program is individualized to each patient* • *Appropriate for patients with complex physical/psychosocial concerns* • *Geriatrician available for consult* ***Catchment area:*** *South of St. Clair Ave., East of Hwy 427, West of Brimley Rd.* ***Exclusion Criteria:*** • *Patient needs more than minimal assist for transfers/ambulation* • *Cognitive difficulties preventing patient participation* • *Under age 65* • *Patient requiring only one service* • *Patient able to receive services in LTC facility or Retirement Home* • *Previous admission to Geriatric Day Hospital in last 2 yrs. with no significant change in status*
Falls Prevention Program	• *Interprofessional assessment by geriatrician, physiotherapist and nurse* • *12-week duration, 1 session per week including group educational lecture and group exercise class* • *Appropriate for patients over the age of 65 at risk for falls* • *Patient must be able to participate in group exercises and learn new information (class only held in English)* ***Exclusion Criteria:*** • *Cognitive or medical issues that would impair participation in group exercise (45 min. in duration, seated/standing)* • *Requires assistance or supervision with transfers or ambulation*

Geriatric Medicine Clinic	• *Comprehensive assessment by a geriatrician (nursing and social work available as needed)*
	• *Common reasons for referral include:*
	  ◦ *Cognitive impairment*
	  ◦ *Complex medical problems and polypharmacy*
	  ◦ *Functional decline or falls*

Geriatric Psychiatry Clinic	• *Consultation by a geriatric psychiatrist*
	• *Common reasons for referral include:*
	  ◦ *Depression, Anxiety*
	  ◦ *Agitation, Aggression*
	  ◦ *Delusions, Hallucinations*

Independence at Home (IAH) Community Outreach Team	• *Multi-disciplinary assessment, care plan development and coordination (team members may include RN, Pharmacy, SW, Geriatrician and Geriatricpsychiatry based on patient's needs)* • *Appropriate for medically and socially complex, community dwelling seniors who have experienced recent functional decline and have potential to regain function or may be struggling for other reasons to remain in the community – i.e. poor connections to community services. Ideal for more home-bound seniors.* • *May include an in-home assessment based on patient's needs* ***Catchment:*** *South of St Clair Avenue, West of the Don River, and East of Keele St./Parkside Dr.* ***Exclusion Criteria:*** • *Under age 65* • *Residing in a Long Term Care Home*

Please fax referral and related ***consultation notes, current medication list and recent investigations*** to (416) 597-7066.

For questions or concerns regarding the IAH Community Outreach Team, please contact (416) 597-3422 x3830. For questions or concerns regarding any other Geriatric Outpatient Services please contact (416) 597-3422 x3065. Toronto Rehab/UHN is a teaching hospital. Trainees may be involved in your care.

Please fax the completed referral and accompanying documentation to (416) 597-7066

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RGP

Referral Form

Geriatric Outpatient Services - Toronto Rehab

Please indicate to which service the patient is being referred. Please note that during the referral review process, patients may be redirected to another of the listed Geriatric Outpatient services if more appropriate. (please refer to p. 1 for service descriptions)

☐ **Geriatric Day Hospital** ☐ **Falls Prevention Program** ☐ **IAH Community Outreach Team** ☐ **Geriatric Medicine Clinic** ☐ **Geriatric Psychiatry Clinic**

Name of Patient: _____ _____ DOB: _____ ☐ M ☐ F
Last Name *First Name* *dd/mm/yyyy*

Address: _____ City: _____ Postal Code: _____

Phone: _____ Health Card #: _____ Version: _____

Emergency Contact: _____ Relationship: _____ Tel: _____

Contact to Arrange Appointment: ☐ Client ☐ Emergency Contact Does client speak English? ☐ Yes ☐ No If No, indicate language: _____

Has the patient/family been informed of this referral? ☐ Yes ☐ No Has the patient been seen by a Geriatrician? ☐ Yes ☐ No Name: _____

Has the patient provided consent to contact family/caregiver(s)? ☐ Yes ☐ No If Yes, Name: _____ Tel.: _____

Transfers: ☐ Independent ☐ Assistance ☐ Not sure **Ambulation:** ☐ Independent ☐ Assistance **Mobility Aid:** _____

Main Concern(s) to be Addressed

Has diagnosis been discussed with patient? ☐ *Yes* ☐ *No*

Medical History / Medication List ☐ **Documentation Attached**

Is patient O_2 dependent? ☐ *Yes* ☐ *No*

Please attach the following documentation:

- ☐ Brain imaging (if available)
- ☐ Bone Mineral Density (if available)
- ☐ Relevant consultation reports (e.g., cardiology, neurology, geriatrics, etc.)
- ☐ Blood work

Reasons for Referral:

Medical
- ☐ Complex comorbidity
- ☐ Medication management
- ☐ Pain management
- ☐ Sleep
- ☐ Constipation
- ☐ Incontinence
- ☐ Swallowing
- ☐ Weight loss/nutrition

Cognitive/Behavioural
- ☐ Cognitive impairment
- ☐ Depression
- ☐ Verbal/physical aggression
- ☐ Delusions/hallucinations

Psychosocial
- ☐ Caregiver issues
- ☐ Social isolation
- ☐ Elder abuse

Functional decline
- ☐ Mobility/falls
- ☐ Speech difficulties

Other: _____

Family MD: _____ Billing #: _____ Phone: _____ Fax: _____

Referring MD/NP: _____ Billing #: _____ Phone: _____ Fax: _____

Referral Initiator: Name: _____ **Organization:** _____
(if different from Referring MD/NP)

Signature of Referring MD/NP: _____ Date: _____

Please fax the completed referral and accompanying documentation to (416) 597-7066