Sinai Health and the University Health Network Geriatric Care Hub (Geri-Hub)

The Geriatric Care Hub (Geri-Hub) is a partnership between Sinai Health and the University Health Network (UHN). The Geri-Hub involves the coordination of Sinai Health and UHN's geriatric outpatient and community based services, in order to connect frail older persons with the right care, in the right place at the right time, by the right providers across a common geographical area. Through a central intake process, patients will be connected with the most appropriate Geri-Hub services being provided by either Sinai Health or UHN.

Geriatric Medicine Clinics - Mount Sinai Hospital and Toronto Rehab

- Geriatric Medicine Clinics assist older adults who have complex conditions associated with aging. The clinics work in partnership with patients' primary care and other specialist providers to offer the specialist support of geriatricians. Comprehensive assessment; care planning recommendations and services; links to other specialist, primary, home and community services; as well as ongoing follow-up, support, health education, and counselling are provided as needed to enable healthy and active living.
  Common concerns addressed include: cognition; falls, functional decline; mobility issues; polypharmacy; weight loss/nutrition; medication review/polypharmacy; incontinence; pain; caregiver support; complex and multiple comorbidities.
- Our Geriatricians also offer **eConsults** as the UHN/Sinai Health Geriatric Medicine eConsult Service via the OTN eConsult platform.

Geriatric Psychiatry Clinics - University Health Network

- Geriatric Psychiatric Clinics work in partnership with patients' primary care and other specialist providers to offer the specialist support of geriatric psychiatrists. Geriatric Psychiatry Clinics provide comprehensive geriatric mental health assessments, and care planning recommendations and services; links to other specialist, home and community mental health services and programs; with potential for ongoing follow-up, support, and health education as needed to enable healthy and active living. These services can be provided to older adults age 65 and above with new onset of mental health challenges (mood, anxiety, psychosis), or to those age 60 and above with dementia and the associated neuropsychiatric symptoms.

Geriatric Rehab Outpatient Services - Toronto Rehab

- ***Geriatric Day Hospital:***
  -Appropriate for patients with complex physical/cognitive/psychosocial concerns requiring two or more of the following services: nursing (RN), physiotherapy, occupational therapy (OT), social work (SW), speech-language pathology (SLP)
  -Up to 10-week duration; program is individualized to each patient
  -Geriatrician available for consultation
- ***Falls Prevention Program:***
  -Appropriate for patients whose primary concern is falls, and patient is at risk for falls
  -Interprofessional assessment by geriatrician, physiotherapist and nurse
  -Access to OT, SW, and SLP services available if identified as needed during initial assessment
  -8-week duration; program includes educational lectures and exercise classes
  -Patient must be able to participate in group based exercise and education sessions
  Exclusion Criteria: Requires assistance or supervision with transfers or ambulation
- ***Learning the Ropes for Living with MCI®:***
  -Appropriate for patients with a diagnosis of amnestic mild cognitive impairment (MCI)
  -Group based education focused on lifestyle factors that can impact cognitive health and memory strategy training.
  -$75 program fee (no one is turned away if they cannot pay fee)
  -The program is held once a week for 6 sessions (approximately 90-105 minutes per session) and there is a follow up session approximately one month after the sixth session.
  -Each participant is able to invite one caregiver/family member/close friend to join the sessions to support their learning.
  -A one time support session will be organized for any caregivers/family members/close friends who are interested.
  Exclusion Criteria for Geriatric Rehab Services:
  -Patient needs more than minimum assistance for transfers/ambulation (patients requiring min assist must be accompanied by a caregiver)
  -Cognitive, physical, or medical difficulties preventing patient participation in program activities
  -Patients residing in Long-Term Care (LTC) or a Retirement Home (RH)
  -Previous admission in last 2 years with no significant change in status

Geriatric Community Outreach Team - Sinai Health, Toronto Rehab, Home and Community Care Support Services (HCCSS)

- ***Independence at Home Community Outreach Team:***
  -Catchment area: South of St. Clair Avenue, North of Lake Ontario, West of the Don River, and East of Parkside Drive/Keele Street.
  -Appropriate for medically and socially complex, community dwelling older adults who have experienced recent functional decline and have potential to regain function, or may be struggling for other reasons to remain in the community – e.g. poor connections to community services. Ideal for more home-bound older adults.
  -Interprofessional assessment, care plan development and coordination (team members may include RN, Pharmacy, SW, Care Coordinator from HCCSS, Geriatrician and Geriatric Psychiatry based on patients' needs). Exclusion Criteria: Patients residing in LTC or a RH

Sinai Health and the University Health Network Geriatric Care Hub (Geri-Hub) Referral Form

Please complete this form and ensure all requested information is included. Mandatory fields are flagged with an asterisk *.

Missing information may result in delay of services. Please note that we do not provide urgent medical care or crisis management services, please direct your patients to other services if needed.

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1. Patient Eligibility (please identify if patient meets the eligibility criteria for services within the Geri-Hub, if no is checked for any of the below criteria please refer your patient to other services):

Patient/SDM/POA is aware, agreeable and consents to referral and sharing of information; and medical diagnoses have been discussed with patient/SDM/POA? ☐ Yes ☐ No

Is the patient age 65 and above, or 60 and above with cognitive concerns? ☐ Yes ☐ No

Does the patient live in the Geri-Hub catchment area or meet the catchment area exception criteria (South of Eglinton Avenue, North of Lake Ontario, West of Bayview Avenue, and East of the Humber River)?: ☐ Yes ☐ No

*Please note catchment area for Independence at Home Community Outreach Team remains South of St. Clair Avenue, North of Lake Ontario, West of the Don River, and East of Parkside Drive/Keele Street.

**Please note if patients receive a majority of their medical care at Sinai Health/UHN an exception will be made to the catchment area.

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2. Patient Information *:

First Name: _____ Last Name: _____Date of Birth (dd/mm/yyyy):_____

Gender:_____ Address: _____ City: _____ Postal Code:_____

Phone Number: _____ Health Card Number and Version Code: _____ Health Card Expiry Date: _____

Patient Lives in: ☐ LTC ☐ RH ☐ Supportive Housing ☐ Private Dwelling

Does patient live alone? ☐ Yes ☐ No Does patient have any support from family/friends? ☐ Yes ☐ No

Does patient receive services from Home and Community Care Support Services (HCCSS)? ☐ Yes ☐ No

If Yes, Name of Care Coordinator: _____ Phone Number: _____

What language does patient speak: ☐ English ☐ Other (specify):_____

Interpreter Required: ☐ Yes ☐ No If yes, specify language:_____

Is the patient a candidate for a Virtual Visit? ☐ Yes ☐ No If yes, using: ☐ Telephone ☐ Video Conferencing

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3. Alternate Contact Information:

Can patient be contacted directly?: ☐ Yes ☐ No

If No, please provide information about the patient's alternate contact (if consent to communicate with alternate contact has been obtained from patient):

Name:_____ Relationship: _____ Phone Number:_____

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4. Referring Source * and Family Physician Information:

Referring MD/NP Name:_____ Phone:_____ Email:_____

Fax:_____ Billing #:_____Signature:_____ Date: _____

Family Physician Information (If different from referral source)

Name: _____ Phone: _____

Fax: _____ Billing #:_____

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5. Reason for Referral* (indicate all that apply):

Specify services needed (if known). Please note patients will be triaged to the most appropriate service(s) based on current issues, wait times.

- ☐ Comprehensive Geriatric Assessment by Geriatrician
- ☐ Assessment by Geriatric Psychiatrist
- ☐ Interprofessional Rehabilitation
- ☐ Memory Strategy Training for patients with a diagnosis of Amnestic MCI
- ☐ Home based assessment and services (for homebound patients)

*Our Geriatricians also offer **eConsults** as the UHN/Sinai Health Geriatric Medicine eConsult Service via the OTN eConsult platform

	Indicate all that apply:	Provide details as applicable:
Medical/Physical	☐ **Recurrent emergency department (ED) visits or admissions in the last 12 months**	
	☐ **Risk/Safety Concerns: (including any physical risk; risk of harm – (e.g. frailty, delirium)**	Specify Risk/Safety Concerns:
	☐ **Falls**	☐ Recurrent falls in the last 3-6 months ☐ Recurrent falls in the last 6 months or more
	☐ **Mobility issues**	Transfer Status: ☐ Independent ☐ Assistance Ambulation Status: ☐ Independent ☐ Assistance Mobility Aid Used: ☐ No Aid ☐Cane ☐Walker ☐ Wheelchair ☐Power Mobility
	Medication Issues: ☐ **Medication Review** ☐ **Medication Management/Adherence Issues**	Indicate if patient is taking any of the following: ☐ Falls and high risk medications e.g. benzodiazepines, opiates, sedating or anti-cholinergic ☐ Narrow therapeutic index medications where missed or duplicated doses may have serious consequences e.g.: insulin, oral hypoglycemic agents, anticoagulants, anticonvulsants, lithium, digoxin Please include full list of medications below.
	☐ **Incontinence**	
	☐ **Constipation**	
	☐ **Pain Management**	
	☐ **Sleep**	
	☐ **Weight Loss/Nutrition**	
Functional	☐ **Functional Decline (a loss of 1 or more ADLs and/or IADLs)**	☐ Acute functional decline in the last 3 months ☐ Functional decline in the last 12 months or more
	☐ **Swallowing**	
	☐ **Speech Difficulties**	
	☐ **Driving Concerns**	
	☐ **Homebound**	Please indicate if any safety risks are present: ☐ pets ☐ bedbugs ☐ communicable diseases ☐ physical aggression ☐ smoking ☐ clutter ☐ building hazards

Cognitive/Behavioural	☐ **Atypical cognitive changes, cause unclear**	
	☐ **Cognitive decline**	☐ Acute cognitive decline in the last 3-12 months ☐ Cognitive decline in the last 12 months or more ☐ Cognition previously assessed by another specialist (indicate date and name of specialist who completed the assessment): _____
	☐ **Behavioural and psychological symptoms of dementia (BPSD) not well managed**	
	☐ **Mood**	
	☐ **Suicidal Ideation**	
	☐ **Verbal/Physical Aggression**	
	☐ **Delusions/Hallucinations**	
	☐ **Wandering**	
	☐ **Substance Abuse**	
	☐ **Self-Neglect**	
Psychosocial	☐ **Caregiver Stress/Risk of Caregiver Burnout**	Indicate if Severe: ☐ Yes ☐No (e.g. caregiver(s) has expressed difficulty with providing ongoing support or being overwhelmed by support needs).
	☐ **Social Isolation/Limited Supports**	Indicate If severe: ☐Yes ☐No (e.g. lives alone with no friend/family support, and no community supports in place)
	☐ **Psychosocial issues**	
	☐ **Concern for Abuse (financial, physical, emotional, sexual, neglect)**	
	☐ **Other:**	Specify:

6. Medical Information:

Medical History * (Please write below, or ☐ check to indicate attachment)

_____

_____

_____

Current Medications and Supplements * **(**Please write below, or ☐ check to indicate attachment)

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Please attach the following if available: ☐ Recent Laboratory Testing (from last 3 months) ☐ Cardiac Tests (ECHO, EKG) ☐ DEXA (Bone Density Scan) ☐ Vaccination Record ☐ Diagnostic Imaging (from last 2 years) ☐ Relevant Consultation Reports ☐ Cognitive Testing (e.g. MoCA, MMSE, RUDAS or Mini-Cog)

Has patient previously seen a Geriatrician?: ☐ Yes ☐ No If Yes, Name:_____ Date:_____
Please list all specialists currently affiliated with the patient and provide contact details wherever possible:

_____

Please complete sections 1-6 of this form and submit by: Fax (416) 597-7066 or Email TRI-Eskerfax.DayHospital@uhn.ca
If you have any questions or concerns, please call (416) 597-3422 ext. 3065