GAIN
Geriatric Assessment & Intervention Network

Referral Form

Please refer only to **one** Team.
The referral will be triaged to the most appropriate GAIN team

GREY **shaded teams provide on-site visits only (patients who are homebound should be referred to the unshaded teams)**
(Note: GAIN does not provide emergency or crisis management services)

SCARBOROUGH		DURHAM	NORTH EAST		
☐ **Scarborough Health Network:** ***General Site*** T: 416-431-8111 F: 416-289-2961	☐ **Carefirst Seniors & Community Services Association** T: 416-847-8941 F: 416-646-5111	☐ **Lakeridge Health Oshawa Hospital** T: 905-576-8711 x 34832 F: 905-743-5311	☐ **Port Hope Community Health Centre** T: 905-885-2626 x 254 F: 905-885-6063	☐ **Trent Hills Community Team (Campbellford)** T: 705-653-1140 x 2139 F: 705-632-2023	☐ **Peterborough Regional Health Centre (PRHC)** <CLINIC>
☐ **Scarborough Health Network:** ***Centenary Site*** T: 416-281-7446 F: 416-281-7082	☐ **Senior Persons Living Connected** T: 416-493-3333 x 311 F: 416-352-5086	☐ **Carea Community Health Centre (Whitby)** T: 289-509-0601 F: 905-665-7178	☐ **Community Care City of Kawartha Lakes (Lindsay)** T: 705-879-4112 F: 705-880-1516	☐ **Haliburton Highlands Health Services (Minden)** T: 705-286-2140 x 3400 F: 705-286-0720	☐ **PRHC** <HOMEBOUND> T: 705-743-2121 x5021 F: 705-876-5058

Name of Client: _____ (*Last name*) , _____ (*First name*) DOB: _____ Language: _____

Address: _____ (*Street Address*) (*City*) (*Province*) (*Postal Code*) Gender: _____

Phone: _____ Other phone: _____ Health Card #_____ (*Version Code*)

Contact Person/SDM/POA (REQUIRED): Who should we contact to book appointment? ☐ Patient ☐ Contact Person

☐ Patient has provided verbal consent for GAIN to contact **CONTACT PERSON/SDM/POA**

Name: _____ Relationship: _____ Phone: _____

Reason(s) for Referral* (REQUIRED):

***Attach supporting documents* (REQUIRED):** *patient profile, consults (i.e., geriatrics, psychiatry, neurology), previous cognitive tests, recent labs/diagnostics*

***EXCLUSION Criteria:**

- Primary referral reason:
  - ❖ Active alcohol/substance misuse
  - ❖ Traumatic brain injury
  - ❖ Developmental disorder
  - ❖ Genetic/chromosomal syndrome
  - ❖ End of life care (refer to Palliative Care Services)
  - ❖ Capacity assessment
- Under 65 years old (except for suspected dementia)
- Unmanaged or inadequately managed major psychiatric illness
- Long-term care residents

Geriatric Health Status (**REQUIRED completed by referring clinician):** *(select one)*

☐ The person's medical conditions are understood and managed; their symptoms may limit some activities, but they are not dependent on others to complete their daily activities
☐ The person has complex co-morbid diagnoses; they may need some or complete assistance with instrumental activities of daily living (e.g. finances, housework) and/or personal care (e.g. bathing, dressing)
☐ The person is bedbound from associated multiple co-morbidities

Primary Care Provider: _____ Phone: _____ Fax: _____

Referred by: ☐ Primary Care ☐ GEM/ED ☐ Inpatient ☐ Specialist ☐ Family/Self ☐ Community Agency ☐ HCCSS ☐ Other

Referral Source Name: _____ Phone: _____ Fax: _____

Billing Number: _____ Signature: _____ Date: _____

Incomplete or illegible referrals will be returned to you for completion