GAIN
Geriatric Assessment & Intervention Network

(affix client label here)

Referral Form

*Note: your referral will be processed by the clientôs nearest GAIN Team

□ **Lakeridge Health Oshawa**
Ph: 905-576-8711x 4832
Fax: 905-743-5311

□ **The Scarborough Hosp.**
Ph: 416-431-8111
Fax: 416-289-2961

□ **Peterborough Regional Health Ctr.**
Ph: 705-743-2121 x 5021
Fax: 705-876-5058

□ **Rouge Valley Health System**
Ph: 416-281-7446
Fax: 416-281-7082

□ **St. Paul's L'Amoreaux Ctr.**
Ph: 416-493-3333
Fax: 416-352-5086

□ **Carefirst Seniors & Community Services Assn.**
Ph: 416-847-8941
Fax: 416-847-8942

□ **Port Hope Community Health Ctr.**
Ph: 905-885-2626x254
Fax: 905-885-6063

□ **Community Care City of Kawartha Lakes**
Ph: 705-879-4112
Fax: 705-880-1516

□ **Oshawa Community Health Ctr.**
Ph: 905-723-0036
Fax: 905-665-7178

□ **Trent Hills Community Team**
Ph: 705-653-1140x2139
Fax: 705-632-2023

□ **Haliburton Highlands Health Services**
Ph:705-286-2140x3400
Fax: 705-286-0720

REFERRAL SOURCE: ☐ **ED Referral** ☐ **Community** ☐ **Post Hospitalization** ☐ **Geriatric Emergency Management Nurse**

TRIAGE: ☐ **Urgent** ☐ **Non urgent**

PATIENT NAME: _____ Date of Birth (D/M/Y): _____

Address: _____ City: _____

Postal Code: _____ Health Card Number: _____

Phone: (Res.): _____ (Alternate): _____ Can attend a clinic visit? Ĭ Yes Ĭ No

CONTACT PERSON INFORMATION:

Contact Person/SDM/Other: _____ Relationship to patient: _____

Phone: (Res.) _____ (Other): _____

Is interpreter required? Ĭ Yes Language: _____ Call and speak with patient directly? Ĭ Yes Ĭ No

Alert - Do not call: _____ (name)

PHARMACY: _____

Phone #: _____ Fax #: _____

PRIMARY HEALTHCARE PROVIDER (MD/NP) NAME: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____ Fax: _____

HEALTH INFORMATION: **(please fill out as completely as possible)**

REASON FOR REFERRAL TO GAIN: _____

□ Multiple complex health problems	□ Psychosocial problems	□ Functional Decline	□ Cognitive Decline
□ At risk/have experienced falls	□ Difficulty coping/isolation	□ Safety concerns	□ Pain
□ Medication assessment	□ Mental Health/Addictions	□ Other : _____	

COMMUNITY SERVICES:

1. **The applicant is currently linked/referred to these services in the community** (please specify):
   1. _____
   2. _____
2. **Is the applicant referred to or receiving any other geriatric services?** (please specify):
   1. _____
   2. _____
3. **Please attach all supporting documents including patient profile, medication list, consultations, recent lab/diagnostic reports, blood work.**

_____ _____

Referring Healthcare Provider Name: (please print) *Signature*

_____ _____

Billing # *Date*