REFERRAL FORM

Please complete all sections below
and attach any pertinent information.

Unit 551 -550 West Broadway
Vancouver, BC, V5Z 1E9
Tel: (604) 620-8784
Fax: (604) 620-8724
E-Mail: Bookings.PGG@shaw.ca

DEMOGRAPHICS:

Patient Name_____DOB (mm/dd/yyyy)_____

PHN _____ Tel_____ Sex: □M □F

Address_____

Primary Contact Name_____Relationship_____

Tel or Email for all appointments_____

REASON FOR REFERRAL (check all that apply):

- □ Comprehensive Geriatric Assessment
- □ Cognitive Impairment
- □ Mobility Concerns (including Balance and Falls)
- □ Polypharmacy
- □ Movement Disorder
- □ Frailty
- □ Geriatric Pre-operative Assessment (please provide details of potential surgery and date)
- □ Multiple Medical Comorbidities
- □ Osteoporosis
- □ HOME VISIT with Care of Elderly Physician *within City of Vancouver only*
- □ Other: _____

Past Medical History:

_____
_____
_____
_____
_____

Please attach recent blood work, imaging, consultations and hospital discharge summaries.

Referring Physician _____ MSP Number_____

Family Physician (if different than Referring)_____

Requested Physician

□ Specific Physician (please specify) _____
□ First Available Geriatrician
□ Osteoporosis Clinic
□ Home Visit