

REFERRAL FORM



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

Please complete all sections below
and attach any pertinent information.

DEMOGRAPHICS:

Patient Name _____ DOB (mm/dd/yyyy) _____

PHN _____ Tel _____ Sex: M F

Address _____

Primary Contact Name _____ Relationship _____

Tel or Email for all appointments _____

Please note our Geriatricians see patients over the age of 65. The exception is for Cognitive Impairment where patients may be younger than 65 years.

REASON FOR REFERRAL (check all that apply):

- Comprehensive Geriatric Assessment
- Cognitive Impairment- (including dementia and Mild Cognitive Impairment)
- Mobility Concerns (including Balance and Falls)
- Polypharmacy
- Geriatric Pre-operative Assessment (please provide details of potential surgery and date)
- Multiple Medical Comorbidities
- Osteoporosis
- Other: _____

Past Medical History: Please list or attach in referral package

Please attach relevant and recent laboratory or radiology reports and relevant consultant reports noting that our physicians have access to CareConnect

Referring Physician _____ MSP Number _____

Requested Physician

Specific Physician (please specify) _____

First Available Geriatrician

Osteoporosis Clinic

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Family Physician (if different than Referring) _____

Requested Physician

- Specific Physician (please specify) _____
- First Available Geriatrician

Osteoporosis Clinic