Referral Form

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

SCARBOROUGH		DURHAM	NORTH EAST		
❒ **Scarborough & Rouge Hospital: General Site** T: 416−431−8111 Fax: 416−289−2961	❒ **Carefirst Seniors & Community Services Association** T: 416−847−8941 Fax: 416−847−8942	❒ **Lakeridge Health Oshawa Hospital** T: 905−576−8711 x 34832 Fax: 905−743−5311	❒ **Port Hope Community Health Centre** T: 905−885−2626 x 254 Fax: 905−885−6063	❒ **Trent Hills Community Team (Campbellford)** T: 705−653−1140 x 2139 Fax: 705−632−2023	❒ **Peterborough Regional Health Centre** T: 705−743−2121 x 5021 Fax:705−876−5058
❒ **Scarborough & Rouge Hospital: Centenary Site** T: 416−281−7446 Fax: 416−281−7082	❒ **Senior Persons Living Connected** T: 416−493−3333 x 311 Fax: 416−352−5086	❒ **Carea Community Health Centre (Whitby)** T: 905−723−0036 x 1409 Fax: 905−665−7178	❒ **Community Care City of Kawartha Lakes(Lindsay)** T: 705−879−4112 Fax: 705−880−1516	❒ **Haliburton Highlands Health Services (Minden)** T: 705−286− 2140 x 3400 Fax: 705−286−0720	

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

Address: _____ City: _____

Phone: _____ Other Phone: _____ Sex: ☐ M ☐ F

Health Card Number: _____ Language: _____

Contact Person/SDM/POA: (REQUIRED)

Name: _____ Relationship: _____ Phone: _____

☐ **Patient has provided verbal consent for GAIN to contact Contact Person/SDM/POA**

Who should we contact to book appointment? ☐ PATIENT ☐ CONTACT PERSON

REASON FOR REFERRAL: (REQUIRED)

Please circle all that apply

1. Cognitive decline affecting hygiene, managing medication, banking, driving and/or meal preparation
2. Complex medication regimen/polypharmacy
3. Recent falls or mobility changes
4. Recent physical or functional decline
5. Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviours)
6. Caregiver(s) having difficulty coping

Patient can attend a clinic visit ☐ Yes ☐ No Reason: _____

***Attach supporting documents (within last year): patient profile, med list, consults, recent labs/diagnostics**
Failure to provide required documentation will delay appointment booking

Pharmacy: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Referred By: ☐ Primary Care ☐ GEM/ED ☐ Inpatient ☐ Specialist ☐ Family/Self ☐ Community Agency ☐ LHIN ☐ Other

Referral Source Contact Information: _____ Date: _____

Billing #: _____ Signature: _____