fraserhealth

REFERRAL FORM
SPECIALIZED SENIORS CLINIC
Regional Older Adult Program

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DATE:

CLINIC LOCATION: Please fax referral to the **PREFERRED** clinic (Refer to back page for clinic addresses)

☐ Abbotsford Clinic (ARHCC)	Fax to: (604) 851-4774
☐ Delta Clinic (DH)	Fax to: (604) 952-7362
☐ Mission Clinic (MMH)	Fax to: (604) 851-4774
☐ New Westminster Clinic	Fax to: (604) 528-5030
☐ Surrey Clinic (JPOCSC)	Fax to: (604) 582-4591
☐ White Rock (PAH)	Fax to: (604) 535-4587
☐ **Family Physician/NP in agreement of referral**	

IMPORTANT: Please attach with referral
LAB RESULTS REQUIRED (within last 3 months):

- ☐ **CBC** ☐ **Electrolytes**
- ☐ **Creatinine** ☐ **TSH**
- ☐ **Calcium** ☐ **B12** ☐ **Albumin**
- ☐ **CT report or diagnostic tests (if available)**
- ☐ **Medical History** (include relevant consultation notes/investigations)
- ☐ **Current medication list** (including prescription, over the counter medications, vitamins & herbal remedies

CLIENT INFORMATION: Please print clearly

Last Name: _____ First name: _____ Middle: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate Phone: _____

PHN #: _____ Sex: ☐ M ☐ F DOB (d/m/y): _____

Client/Family in agreement of referral ☐ Yes ☐ No Comments: _____

Contact Person for Scheduling: _____ Phone: _____ Relationship: _____

Primary Language: _____ Translator needed? ☐ Yes ☐ No

REFERRING SOURCE:

☐ Primary Care/Family Physician ☐ Nurse Practitioner ☐ Specialist ☐ RN
☐ Mental Health & Addictions ☐ Home Health ☐ Other:

Name:

Phone: Fax:

Family Physician (if different from referring source)

Name: _____

Phone: _____

Fax: _____

Client Location at Time of Referral: ☐ Community ☐ Emergency Department ☐ Acute Care ☐ Acute Care of Elder (ACE) Unit

Primary Reason for Referral (Choose 1 only)

☐ Memory/cognitive changes ☐ Behavioral changes ☐ Multiple falls of unknown origin
☐ Change in function (ADL &/or IADL) (**specify**): _____
☐ Complex medical issues (**specify**): _____
☐ Failure to thrive (**specify**): _____
☐ Comments: _____

Secondary Reason(s) for Referral

☐ Memory/cognitive changes ☐ Behavioral changes ☐ Falls or High Fall Risk ☐ Polypharmacy ☐ Wt. Loss/nutrition ☐ Depression
☐ Mood/anxiety changes ☐ Continence issues (urine/stool) ☐ Caregiver stress ☐ Need for social support
☐ Change in function (ADL &/or IADL): _____
☐ Failure to thrive (**specify**): _____
☐ Complex medical issues(**specify**): _____

Print Shop # 261929

REFERRAL FORM
SPECIALIZED SENIORS CLINIC Cont'd

WHO CAN REFER TO THE CLINIC

- Primary Care physician/family physician, nurse practitioner, specialist, registered nurse, allied health professional, Home Health and Mental Health & Addictions.

INCLUSION CRITERIA

- Primary care physician/Family physician or Nurse Practitioner is in agreement with the referral to the Specialized Seniors Clinic
- Resides in Fraser Health
- Usually 65 years of age and older (or younger on a case-by-case basis)
- An older adult with complicated health needs requiring a comprehensive interdisciplinary geriatric assessment
- Mild to moderately frail

EXCLUSION CRITERIA

- Requires competency assessment for medico-legal purposes (e.g. acquired brain injury)
- Psychotic clients with primary psychiatric illness
- Known to be actively suicidal
- Residential care facility referrals will be considered on a case-by-case basis

Clinic	Location	Address	Clinic Phone
Abbotsford	Abbotsford Regional Hospital & Cancer Centre (ARHCC)	32900 Marshall Road Abbotsford, B.C. V2S 0C2	(604) 851-4775
Delta	Delta Hospital (DH)	5800 Mountain View Blvd. Delta, B.C. V4K 3V9	(604) 946-1121 Ext. 783062
Mission	Mission Memorial Hospital (MMH)	Contact address: 32900 Marshall Road Abbotsford, B.C. V2S 0C2	(604) 851-4775
New Westminster	New Westminster	#232- 230 Ross Drive, New Westminster, B.C. V3L 0B2	(604) 528-5031
Surrey	Jim Pattison Outpatient Care and Surgery Centre (JPOCSC)	9750 140th Street Surrey, B.C. V3T 0G9	(604) 582-4582
White Rock	Peace Arch Hospital (PAH), Berkeley Pavilion	15521 Russell Avenue White Rock, B.C. V4B 2R4	(604) 535-4577