



St. JOSEPH'S CARE GROUP

**SPECIALIZED GERIATRIC SERVICES (SGS)  
OUTPATIENT REFERRAL**

Place Patient Label with  
Barcode Here

- Geriatric Medicine • Geriatric Psychiatry • Seniors Outpatient Services Assessment & Rehabilitation • Manor House Adult Day Program • Geriatric Telemedicine
- Behavioural Supports (BSO) Mobile Outreach Team • Psychogeriatric Resource Consultant (PRC)
- Missing or incomplete information will delay processing
- Fax completed referral form with relevant attachments to SGS Central Intake at:  
Fax: **807-345-5126**. Any questions please call SGS Central Intake at 807-346-5218

<b>Client Information:</b>		Health Card #:	D.O.B (d/m/y):
Name: Last	First		Marital Status:
Primary address:			Gender:
Spoken language:		Is a translator required?	Telephone:
		Yes	No
<b>Primary Contact Person For Appointments:</b>			
Name:		Relationship:	
Contact telephone #:		Client/SDM Consent to Referral: Yes No	
Consent to contact? Yes No			

**Reason for Referral:**

**Medical History** (including relevant consult notes and most recent medication list / MARS):  
Check to indicate attachment:

**Test Results** Please send most recent labs/diagnostic's Check to indicate attachment:  
**Laboratory Results:** CBC    Electrolytes    Urinalysis    Creatinine    TSH    Glucose  
                          Calcium    B12    Brain Imaging    Recent EKG    Other relevant diagnostics

**Family Physician/NP** (if different from referring)  
Name: \_\_\_\_\_  
in agreement with referral Yes No

**Client location** at time of referral: Community LTC  
ER    Inpatient Specify:

**Referring Physician/Nurse Practitioner/MRP:**

Signature: _____	Contact #:
Print Name:	Fax#:
Date:	OHIP Billing#

