Good Samaritan
Seniors' Clinic Referral Form

8861 75 Street NW, Edmonton, AB T6C 4G8
Phone: 780-440-8274 Fax: 780-469-6495
Email: seniorsclinic@gss.org

PROGRAM DESCRIPTION

The Seniors' Clinic provides both primary care and consultative services to the vulnerable, community-based senior population with complex medical, functional and/or psychosocial needs. The clinic team (Physicians, Social Worker, Nurse Practitioner and Nurses) offers specialized seniors care with the goal of supporting seniors to remain at home or in the community for as long as possible. New patients can be referred to the clinic by anyone including themselves or family members. The clinic is open Monday to Friday from 9:00am to 4:00pm and has an on-call physician available after hours.

PROCESS FOR APPOINTMENT

1. Please return completed form and applicable attachments via:
   - **Fax: 780-469-6495** or
   - **Email:** seniorsclinic@gss.org (please read submission guidelines below)
2. Must attach:
   - ☐ List of medications
3. Attach, if available: *(please check those that apply)*
   - ☐ Cognitive tests (e.g. MMSE, MoCA)
   - ☐ Geriatric Depression Scale
   - ☐ Goals of Care
4. **Incomplete forms will delay the referral process. An email/ fax will notify referral source of missing information.**
5. Patient or primary contact person will be notified via email (preferred), fax or mail within two weeks.
6. **If family physician is involved, please make aware of referral as they will be notified of appointment information.**

Submission Guidelines
It is the responsibility of the person submitting this form to the Seniors' Clinic to maintain the confidentiality of the information. Special note about using e-mail; the Seniors' Clinic will not send personal information or personal health information using unencrypted e-mail. If you choose to submit this form via unencrypted e-mail the Seniors' Clinic cannot assume responsibility for maintaining the confidentiality of the information during transmission. The Seniors' Clinic can only protect personal information and personal health information once it has been received by the Seniors' Clinic.

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Patient Label

A. PATIENT / APPLICANT INFORMATION

Last Name:	First Name:	Initial:	Gender: ☐ Female ☐ Male
Date of Birth (*year-month-day*)	Alberta Personal Health Number		
Address (unit/suite, street):		City/Town:	
Postal Code:	Patient Phone:	Patient Email:	

Living Arrangements / Language

Please Specify: ☐ House ☐ Apartment/Lodge ☐ Facility _____

Lock Box Code (if applicable): _____

Patient lives with: ☐ Spouse ☐ Children ☐ Alone ☐ Other: _____

Able to Leave the Home: ☐ Yes ☐ No

If No, **MUST** explain: _____

_____

Preferred Language: ☐ English ☐ Other: _____

Interpreter Needed *(Patient to provide if required):* ☐ Yes ☐ No

Contacts

Contact Name to Book Appointment (if different than the patient): _____

Relationship to Patient:	Phone:	Email:

Family Physician Name: _____ ☐ No Family Doctor

Address:	Phone:	Aware of Referral: ☐ Yes ☐ No

B. REFERRAL INFORMATION

Referral Request: (choose one)

☐ Primary Care (Seniors' Clinic doctor becomes family doctor)

☐ Consultative Care (Seniors' Clinic doctor provides recommendations to current family doctor or other health care professional)

☐ Telephone Consult (Seniors' Clinic doctor provides suggestions to Health Care Professional based on the Health Care Professional's assessment)

Is the patient available on short notice if there is a cancellation? ☐ Yes ☐ No

Contact Name: _____ Phone Number: _____

Referral Source *(Select One)*

Referral Source: ☐ Self/Patient ☐ PCN ☐ Home Care ☐ CHOICE

☐ Family Member ☐ Family Physician ☐ Other: _____

Name:	Phone:	Fax:	Email:
Address:	City/Town:	Postal Code:	

THE GOOD SAMARITAN SOCIETY

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C. MANDATORY PATIENT INFORMATION:

1. Is there a concern the patient has forgetfulness or memory loss? ☐ Yes ☐ No
2. Has patient been to emergency or admitted to hospital in the last three months? ☐ Yes ☐ No
3. Is there a concern the patient needs more help than can be provided at home? ☐ Yes ☐ No
4. Does the patient have difficulty with any of the following (check all that apply)?
   - ☐ Walking
   - ☐ Dressing
   - ☐ Managing money or bills
   - ☐ Cooking
   - ☐ Telephone
   - ☐ Toileting
   - ☐ Taking medications
5. In reference to question #4, has there been any change in any of the above in the last two months? ☐ Yes ☐ No
6. Has the patient had a previous Geriatric Assessment? ☐ Yes ☐ No ☐ Unsure

D. MEDICAL HISTORY

- ☐ COPD
- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Osteoarthritis
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Depression
- ☐ Osteoporosis
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Diabetes
- ☐ Atrial Fibrillation
- ☐ Chronic Kidney Disease
- ☐ Other: _____

E. REASON FOR REFERRAL *Please elaborate and be specific about what concern(s) you would like addressed.*

Submit