Good Samaritan Seniors' Clinic Referral Form

8861 75 Street, 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
   - **E-mail:** 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.

THE GOOD SAMARITAN SOCIETY

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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		☐No Family Doctor	
Name	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	Postal Code

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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 ☐Toileting ☐Cooking ☐Telephone ☐Managing money or bills ☐Taking medications			
5. In reference to question #4, has there been any change in any of the above in the last three months?	☐Yes	☐No	
6. Has the patient had a previous Geriatric Assessment?	☐Yes	☐No	☐Unsure

D. MEDICAL HISTORY

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

_____

E. ALLERGIES (LIST BELOW)

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

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FORM COMPLETION DATE: