



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. **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 <input type="checkbox"/> Female <input type="checkbox"/> 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 <input type="checkbox"/> House <input type="checkbox"/> Apartment/Lodge <input type="checkbox"/> Facility _____ Lock Box Code (if applicable) _____			
Patient Lives With <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Alone <input type="checkbox"/> Other _____			
Able to Leave the Home <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, MUST explain _____ _____	
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Other _____		Interpreter Needed (Patient to provide if required) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contacts			
Contact Name to Book Appointment (if different than the patient)	Relationship to Patient	Phone	Email
Family Physician		<input type="checkbox"/> No Family Doctor	
Name	Address	Phone	Aware of Referral <input type="checkbox"/> Yes <input type="checkbox"/> No
B. REFERRAL INFORMATION			
Referral Request (choose one) <input type="checkbox"/> Primary Care (Seniors' Clinic doctor becomes family doctor) <input type="checkbox"/> Consultative Care (Seniors' Clinic doctor provides recommendations to current family doctor or other health care professional). <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Contact Name:		Phone Number:	
Referral Source (Select One)			
Referral Source <input type="checkbox"/> Self/Patient <input type="checkbox"/> PCN <input type="checkbox"/> Home Care <input type="checkbox"/> CHOICE <input type="checkbox"/> Family Member <input type="checkbox"/> Family Physician <input type="checkbox"/> Other _____			
Name	Phone	Fax	Email
Address		City	Postal Code



Patient Label

C. MANDATORY PATIENT INFORMATION

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

D. MEDICAL HISTORY

<input type="checkbox"/> COPD	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Dementia	<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Depression	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cerebrovascular Accident (Stroke)
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Myocardial Infarction (Heart Attack)
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Chronic Kidney Disease
<input type="checkbox"/> Other _____	

E. ALLERGIES (LIST BELOW)

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

FORM COMPLETION DATE: _____