Providence Care

PERSONAL HEALTH INFORMATION

SENIORS DAY REHABILITATION REFERRAL

Fax referral to Providence Care Central Intake 613-548-5595
Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral.

PATIENT/CLIENT DEMOGRAPHICS		RELATIONSHIP TO PATIENT/CLIENT
NAME ☐ M ☐ F		Living Arrangement ☐ With Spouse ☐ Alone ☐ Other
Address		Next of Kin / Primary Contact
Telephone (Home)		Relationship to Patient/Client
Date of Birth		Telephone (Home)
Health Card #		Telephone (Other)

French Language Services Required? ☐ Yes ☐ No

TO BE COMPLETED BY PROVIDENCE CARE STAFF

Interpreter ☐ Family ☐ Professional ☐ Staff ☐ Volunteer
Format ☐ Written ☐ Verbal ☐ Both
Transportation ☐ Drives Self ☐ Family ☐ Volunteer ☐ Friend ☐ Other

REFERRAL INFORMATION ***(the following is to be filled in by the physician or nurse)***

Referral Source: *(eg. family physician, team nurse, CCAC)*	Telephone:	Fax:

IS FAMILY PHYSICIAN AWARE OF THIS REFERRAL? ☐ Yes ☐ No

*(If the family physician **has not been made aware of the referral**, please be advised it is part of Specialized Geriatrics practice to do so)*

Family Physician Name _____ Telephone _____ Fax # _____

Address _____

PRESENTING CONCERNS AND CURRENT MEDICAL ISSUES *(Please provide any additional documentation that will be relevant to our assessment and the care of your patient/client. Please include a current list of medications. EMR PRINTOUTS ARE VERY HELPFUL).*

☐ Multiple medical concerns ☐ Cognition ☐ Falls ☐ Medications ☐ Depressed mood
☐ Caregiver stress ☐ Urinary incontinence ☐ Driving ☐ Safety concerns ☐ Mobility
☐ Nutrition ☐ Swallowing ☐ Communication

Reason for referral:

☐ **Current list of medications/eMAR**
☐ **Relevant medical history/documentation**

Signature ☐ MD ☐ RN(EC) YYYY/MM/DD

(If at all possible, please provide MD or RN(EC) signature)

OF NOTE: If the reason for referral is dementia without concurrent medical issues or for behavioural issues related to dementia, consider referral to Seniors Mental Health in your area

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SENIORS DAY REHABILITATION

REFERRAL CRITERIA

Frail older adults with complex health issues, decline in coping and/or managing day to day activities, mobility challenges, recent falls or fear of falling, medication concerns, multiple hospital admissions or Emergency Department visits, mood/memory/thinking changes as part of other health changes, recent unexplained changes in health status, changes in swallowing and/or nutritional status. Appropriate candidates are those with the potential to adequately improve functional loss in avoidance of repeat Emergency Department visits, inpatient admission or admission to long term care. Patients may come from hospital or the community directly but no longer require nursing care, are able to be managed at home and live close enough to be able to participate in ambulatory services. Patients requiring greater than mild to moderate assistance with toileting or transfers, exhibiting wandering, exit seeking or aggressive behaviours are not appropriate for this service.

TYPE OF SERVICE

Offers inter-professional assessment and intervention for community dwelling seniors who have experienced a recent functional loss or decline in coping and/or managing day to day activities. Evidence based care includes the provision of time-limited, inter-professional therapeutic services two times per week for cognitive needs, continence, self-care, mobility, nutrition and swallowing, chronic disease management, driving concerns and secondary prevention (Physician supported stream). There are two streams - the physician supported and the non-physician supported. Non-physician supported services include PT, OT, SW and SLP.