## Geriatric Outpatient Services – Toronto Rehab

### Service | Criteria for referral
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**Geriatric Day Hospital** | • Outpatient rehab for patients over the age of 65 requiring two or more of the following services: nursing, physiotherapy, occupational therapy, social work, speech-language pathology, therapeutic recreation  
• Up to 10-week duration, 2 sessions/week; program is individualized to each patient  
• Appropriate for patients with complex physical/psychosocial concerns  
• Geriatrician available for consult  
**Catchment area:** South of St. Clair Ave., East of Hwy 427, West of Brimley Rd.  
**Exclusion Criteria:**  
• Patient needs more than minimal assist for transfers/ambulation  
• Cognitive difficulties preventing patient participation  
• Under age 65  
• Patient requiring only one service  
• Patient able to receive services in LTC facility or Retirement Home  
• Previous admission to Geriatric Day Hospital in last 2 yrs. with no significant change in status

**Falls Prevention Program** | • Interprofessional assessment by geriatrician, physiotherapist and nurse  
• 12-week duration, 1 session per week including group educational lecture and group exercise class  
• Appropriate for patients over the age of 65 at risk for falls  
• Patient must be able to participate in group exercises and learn new information (class only held in English)  
**Exclusion Criteria:**  
• Cognitive or medical issues that would impair participation in group exercise (45 min. in duration, seated/standing)  
• Requires assistance or supervision with transfers or ambulation

**Geriatric Medicine Clinic** | • Comprehensive assessment by a geriatrician (nursing and social work available as needed)  
• Common reasons for referral include:  
  ° Cognitive impairment  
  ° Complex medical problems and polypharmacy  
  ° Functional decline or falls

**Geriatric Psychiatry Clinic** | • Consultation by a geriatric psychiatrist  
• Common reasons for referral include:  
  ° Depression, Anxiety  
  ° Agitation, Aggression  
  ° Delusions, Hallucinations

**Independence at Home (IAH) Community Outreach Team** | • Multi-disciplinary assessment, care plan development and coordination (team members may include RN, Pharmacy, SW, Geriatrician and Geriatricpsychiatry based on patient’s needs)  
• Appropriate for medically and socially complex, community dwelling seniors who have experienced recent functional decline and have potential to regain function or may be struggling for other reasons to remain in the community – i.e. poor connections to community services. Ideal for more home-bound seniors.  
• May include an in-home assessment based on patient’s needs  
**Catchment:** South of St Clair Avenue and O’Connor Drive., West of Greenwood Ave., and East of Keele Street  
**Exclusion Criteria:**  
• Under age 65  
• Residing in a Long Term Care Home

Please fax referral and related consultation notes, current medication list and recent investigations to (416) 597-7066.

For questions or concerns regarding the IAH Community Outreach Team, please contact (416) 597-3422 x3830. For questions or concerns regarding any other Geriatric Outpatient Services please contact (416) 597-3422 x3065. Toronto Rehab/UHN is a teaching hospital. Trainees may be involved in your care.

Please fax the completed referral and accompanying documentation to (416) 597-7066
**Referral Form**

**Geriatric Outpatient Services - Toronto Rehab**

Please indicate to which service the patient is being referred. Please note that during the referral review process, patients may be redirected to another of the listed Geriatric Outpatient services if more appropriate. (please refer to p. 1 for service descriptions)

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<th>Geriatric Day Hospital</th>
<th>Falls Prevention Program</th>
<th>IAH Community Outreach Team</th>
<th>Geriatric Medicine Clinic</th>
<th>Geriatric Psychiatry Clinic</th>
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Name of Patient: __________________________  DOB: ______/______/______  Gender: M  F

Address: __________________________  City: __________________________  Postal Code: __________

Phone: __________________________  Health Card #: __________________________  Version: __________________________

Emergency Contact: __________________________  Relationship: __________________________  Tel: __________________________

Contact to Arrange Appointment: ☐ Client ☐ Emergency Contact  Does client speak English? ☐ Yes  ☐ No  If No, indicate language: __________

Has the patient/family been informed of this referral? ☐ Yes ☐ No  Has the patient been seen by a Geriatrician? ☐ Yes ☐ No  Name: __________________________

Has the patient provided consent to contact family/caregiver(s)? ☐ Yes ☐ No  If Yes, Name: __________________________  Tel.: __________________________

Transfers: ☐ Independent  ☐ Assistance  ☐ Not sure  Ambulation: ☐ Independent  ☐ Assistance  Mobility Aid: __________

**Main Concern(s) to be Addressed**

Has diagnosis been discussed with patient? ☐ Yes ☐ No

**Reasons for Referral:**

- **Medical**
  - Complex comorbidity
  - Medication management
  - Pain management
  - Sleep
  - Constipation
  - Incontinence
  - Swallowing
  - Weight loss/nutrition

- **Cognitive/Behavioural**
  - Cognitive impairment
  - Depression
  - Verbal/physical aggression
  - Delusions/hallucinations

- **Psychosocial**
  - Caregiver issues
  - Social isolation
  - Elder abuse

- **Functional decline**
  - Mobility/falls
  - Speech difficulties

**Other:** __________

**Medical History / Medication List**

☐ Documentation Attached

Is patient O₂ dependent? ☐ Yes ☐ No

Please attach the following documentation:

☐ Brain imaging (if available)
☐ Bone Mineral Density (if available)
☐ Relevant consultation reports (e.g., cardiology, neurology, geriatrics, etc.)
☐ Blood work

**Please attach the following documentation:***

| Family MD: __________________________ | Billing #: __________________________ | Phone: __________________________ | Fax: __________________________ |
| Referring MD/NP: __________________________ | Billing #: __________________________ | Phone: __________________________ | Fax: __________________________ |
| Referral Initiator: Name: __________________________ | Organization: __________________________ | (if different from Referring MD/NP) |
| Signature of Referring MD/NP: __________________________ | Date: __________________________ |

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