Vancouver Coastal Health
Promoting wellness. Ensuring care.

Richmond Community Health Access Centre
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GERIATRIC ASSESSMENT PROGRAM REFERRAL FORM

GAP IS NOT AN EMERGENCY SERVICE

We kindly remind you that we are a Geriatric Internal Medicine service. We are not equipped to assist you with:

- Acute Illness
- Routine home visits
- End-stage disease requiring palliative care
- Stand-alone driving evaluations
- Medico-legal Assessments
- Assessments solely for facility placement
- Referrals for stand-alone Physiotherapy, Occupational Therapy or Case Management

For patients with aggressive behavior / elopement risk / primary psychiatric illness / active suicidality, please refer to Mental Health and Substance Abuse Central Intake

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Date of Referral: _____

Patient's Last Name:_____First Name: _____Gender: _____

PHN: _____ Date of Birth: _____Phone: _____

Home Address:_____

Does the patient live alone? Yes ☐ No ☐ Is the patient able to leave the home? Yes ☐ No ☐

Interpreter required? Yes ☐ No ☐ Specify language: _____

Caregiver / Substitute Decision Maker / Primary Contact Info **Required**

Last Name: _____First Name: _____

Phone: _____Relationship to Patient: _____

Appointment to be made with caregiver? Yes ☐ No☐ If no, with whom (name & phone) _____

Consent from patient for caregiver to be contacted? Yes ☐ No☐

Patient eligibility:

Please ensure your patient is eligible for our program by checking the following:

- ☐ **70 years or older**
- ☐ **Consents to participate in our program.**
- ☐ **Lives in Richmond**
- ☐ **Has a primary care provider**

NEW REQUIREMENTS: Patients must be referred by a physician or NP. All patients must have a primary care provider, and -

- Within 3 Months of Referral: In-person patient assessment, by referring provider, for referral question(s)
- Within 6 Months of Referral: CBC, electrolytes, creatinine, B12, calcium, TSH, albumin, syphilis serology, ECG, liver enzymes.
- With Referral Form: All relevant consultations, diagnostic imaging, cognitive testing, discharge summaries

Reason(s) for Referral:

Referring Physician Name: _____Referring Physician Signature:_____

Phone #: _____Fax #: _____MSP #: _____

Family Physician Name & MSP # (if different from referring physician): _____