Hôpital Régional de Pembroke Regional Hospital

Mobile Geriatric Day Hospital
705 Mackay Street
Pembroke, ON K8A 1G8
T: (613) 732-3675 x.8048
F: (613) 633-4581
www.pemreghos.org

EXTERNAL REFERRAL FOR RENFREW COUNTY MOBILE GERIATRIC DAY HOSPITAL

Addressograph

Patient name: _____ CPI: _____ DOB: _____ M / F
YYYY/MMM/DD
Patient telephone: _____ HCN: _____ _____
Address: _____
Contact person for appointment: _____ Relationship: _____
Contact number: _____ Family physician: _____
Referring physician: _____
Past Medical history:
_____

Drug Profile list attached ☐ or Medication list: _____
_____
Pharmacy: _____ Allergies: _____

Current community services: _____

Referral site: ☐ Pembroke ☐ Renfrew
Urgent referral: ☐ Yes ☐ No

Reason for Referral:

☐ Cognition ☐ Mobility ☐ Falls
☐ Driving ☐ Mood ☐ Incontinence
☐ Polypharmacy ☐ Future planning ☐ Pain management
☐ Other: _____

Exclusion Criteria:

- acute unstable medical condition, eg: recent MI or CVA,
- an infectious/contagious condition
- unable to follow 2 step commands
- can not tolerate 30 minutes of low level activity (sitting exercise)
- previous diagnosis of moderate to severe dementia preventing the patient from being able to participate in the Mobile Geriatric Day Hospital Program.

***Urgency criteria**

Non-urgent – at risk of functional decline and have 2 or more issues if addressed will enable them to remain at home longer.

Urgent – newly identified or progressive concerns about cognition/functional status/behaviours (often delirium, driving, medication, falls)

Thank you for your referral. Please attach any relevant discharge summaries and /or test results.
Please fax to 613-633-4581

GERIATRIC EMERGENCY MANAGEMENT REFERRAL FOR RENFREW COUNTY MOBILE GERIATRIC DAY HOSPITAL

Issue	**Active problem**	**Comments**
Cognition Does patient drive?	☐ Yes ☐ No ☐ Yes ☐ No	
Mood	☐ Yes ☐ No	
Behaviour ETOH Smoking	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Mobility Falls	☐ Yes ☐ No ☐ Yes ☐ No	Gait aids? ☐ Cane ☐ 2WW ☐ 4WW
Function a) ADL b) IADL	 ☐ Yes ☐ No ☐ Yes ☐ No	
Nutrition	☐ Yes ☐ No	
Medication concerns?	☐ Yes ☐ No	
Continence (Bladder/bowel)	☐ Yes ☐ No	
Skin integrity	☐ Yes ☐ No	
Pain	☐ Yes ☐ No	
Caregiver Issues	☐ Yes ☐ No	
Other	☐ Yes ☐ No	
Completed by:_____ Date: _____ YYYY/MMM/DD Physician Signature: _____ Date: _____ YYYY/MMM/DD		