Vancouver Coastal Health
Promoting wellness. Ensuring care.

West Community Health Centre
#241 - 2121 Marine Drive, West Vancouver, BC, V2V 4Y2
Tel: 604-904-6200 x 5 Fax: 604-904-6172

GERIATRIC ASSESSMENT CLINIC REFERRAL

NOTE: WE ARE NOT AN EMERGENCY SERVICE

Name of Client _____ (*Last Name*) _____ (*First Name*) Male☐ Female☐

PHN # _____ DOB: _____ Phone # _____

Email: _____ Interpreter Required, Language: _____

Preferred Contact for appointment reminder: ☐Text ☐Email

Address _____ (*Suite Street Address*) _____ (*Postal Code*) _____ (*City*)

Alternate Contact _____ Relationship_____ Phone # _____

Contact Person for Booking Appointment? ☐ Client ☐Alternate Contact

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Urgent? ☐**Yes** ☐**No**

Reason for Urgency: _____

We cannot Triage or book this patient until we have received the following:

☐ Blood Work Results in the Past Year ☐Imaging Reports (Non Health Authority)

☐Previous Neurological, Geriatric or Psychiatric consult (Non Health Authority) ☐Current List of Medications

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REASON(S) FOR REFERRAL

☐Falls/Mobility	☐Cognition	☐Functional Decline (ADL/IADL)
☐Weight Loss/Nutrition	☐Mood	☐Caregiver/Family Issues
☐Incontinence	☐Sleep	☐Neglect/Abuse
☐Pain	☐Behaviour	☐Medical
☐Polypharmacy	☐Safety	☐Other:_____

MEDICAL INFORMATION – Concern(s) to be Addressed:

MEDICAL HISTORY: Please Attach

Name of Family Doctor: _____ Tel:_____ Fax:_____

Name of Referring Physician:_____ Tel: _____ Fax: _____

Signature of Referring Physician:_____ Billing #:_____ Date:_____

OFFICE USE ONLY *Tracking Record Date contacted* APPOINTMENT DATE:

REFERRAL RECEIVED ☐ 1. 2. 3. TIME: