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 4112 Fax: 604-904-6172

GERIATRIC ASSESSMENT CLINIC REFERRAL

NOTE: WE ARE NOT AN EMERGENCY SERVICE

Name of Client ______________________ ______________________ Male☐ Female☐
Last Name *First Name*

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

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
☐ Previous Neurological, Geriatric or Psychiatric Assessments
☐ Current List of Medications

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: