ST. MICHAEL'S UNITY HEALTH TORONTO
RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

Elders' Clinic

Outpatient Geriatric Medicine

30 Bond St. 9 Donnelly Wing
Toronto ON M5B1W8
Tel: (416) 864 - 5015
Fax: (416) 864 - 5735

Estimated wait time for initial consultation is 9-12 months. Urgent requests cannot be guaranteed to be seen in < 3 months. **Our catchment is South of Bloor to the lake, East of Yonge, and West of Don Valley.**

☐ **1st AVAILABLE**
☐ Dr. Alston ☐ Dr. D'Silva ☐ Dr. Zorzitto *(currently not accepting referrals)*
☐ Dr. Watt ☐ Dr. Eric Wong ☐ Dr. Camilla Wong *(internal pre-op/TAVI only)*

Catchment Eligibility: Referrals outside of our catchment not meeting exception criteria (numerous SMH specialists, receiving dialysis or chemotherapy at SMH, discussed with geriatrician) may be declined and suggested to be directed to another geriatric program: https://tinyurl.com/3sh33dj7 .

Patient name	Preferred language
DOB / Gender	Translator required? ☐ Yes ☐ No
Health card #	Alternate Contact *(*required for collateral history)*
Address	Relationship
	Alternate phone #
Phone #	Who should be contacted regarding appointment ☐ Patient ☐ Alternate Contact
Email address	
Candidate for Video Appointment ☐ **Yes** ☐ **No**	Does patient consent to referral? ☐ Yes ☐ No *If no, why?*

Reason(s) for referral* ☐ *Cognitive decline*** ☐ Functional decline ☐ Other
☐ Pain ☐ Falls/Mobility ☐ Multiple medical conditions
☐ Mood ☐ Polypharmacy

** Must have at least **ONE** identified geriatric concern*
***See below for suggested initial workup for cognitive impairment*

Details

Please include the following (if unavailable on Connecting Ontario):
☐ Cumulative patient profile
☐ Recent labwork within 6 months of referral
☐ Relevant investigations if available (neuro imaging, ECG, BMD)
*****Recommended workup for cognitive decline:** CBC, lytes, Cr, glc, Ca, alb, B12, TSH, neuroimaging (MRI preferred)*-**completion prior to assessment enhances quality of visit**
☐ Relevant consult notes if available (ie. geriatrics, neurology, psychiatry, cardiology)
☐ Prior cognitive testing if available

Referring provider	Signature Date
Office address	OHIP Billing #
Phone number	Fax number
Primary care provider *(if different from referring)*	Phone Number Fax

Note to specialists: we may contact the primary care provider for additional information or suggest they refer to another site if patient is not in our catchment.

We are not responsible for patient care until they are seen for initial consultation

PLEASE FAX COMPLETED REFERRAL TO 416-864-5735

Incomplete referrals will delay processing until minimum required information is received