

**NOTE: Incomplete and / or unsigned requisitions will be returned**  
 MARKHAM STOUFFVILLE HOSPITAL CORPORATION

PLEASE PRINT CLEARLY  
 OR AFFIX LABEL WITH COMPLETE INFORMATION

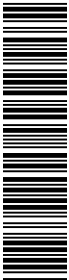
**SENIORS' HEALTH CLINIC REFERRAL**

Dr. Raza Naqvi, MD, FRCPC  
 Nafeesa Fatima, RN (EC), MN, NP-Adult  
 Trini Das, RN (EC), MN, NP-Adult

Markham Site Booking Line: (905) 472-7601  
 Fax: (905) 472-7621

Patient Name (Last, First): \_\_\_\_\_  
 Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Sex: F M  
 Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone # (Best Daytime): \_\_\_\_\_  
 Alternate #: \_\_\_\_\_  
 Email: \_\_\_\_\_

Date	Referring MD/NP	Signature	MD/NP Phone #	MD/NP Fax #
Family MD/NP (if different from Referring MD/NP)		Family MD/NP Phone #	Family MD/NP Fax #	CPSO/CNO#
Additional Reports to:				
Translator/contact person for scheduling			Language spoken if other than English <b>Please bring translator to appointment if required</b>	
Lives alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is patient homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status	Is client/substitute decision maker aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Criteria for Referral</b> - check all that apply <input type="checkbox"/> Age 70 years or older - unless suspected early onset dementia <b>AND at least one of:</b> <input type="checkbox"/> Cognitive changes <input type="checkbox"/> Multiple falls <input type="checkbox"/> Polypharmacy/de-prescribing <input type="checkbox"/> Functional decline <input type="checkbox"/> Physically able to attend outpatient clinic at hospital (fully accessible)			<b>Exclusion criteria</b> <input checked="" type="checkbox"/> Acute change (i.e. suspected Delirium) <input checked="" type="checkbox"/> Request for Medical Assistance in Dying <input checked="" type="checkbox"/> Issues related to capacity assessments, designating POA, wills, estate planning or other non-medical reasons for referral <input checked="" type="checkbox"/> Homebound (please refer to Geriatric Outreach Team. Tel.: (905) 201-3389 Fax: (905) 201-5580)	
<b>Medical Information</b> Medical history: <input type="checkbox"/> Documentation/notes attached				
Medications: <input type="checkbox"/> Documentation attached				
Other:				



**NOTE: Patient/family will be contacted directly with appointment date/time**