ALBERTA CENTRE FOR HEALTHY AGING
WELLNESS AND VITALITY

Referral Form

Suite 910 – 10201 Southport Rd SW,
Calgary, AB T2W 4X9
Phone: 403-300-2476
Fax: 403-538-6433
Email: achamedical@gmail.com

PATIENT INFORMATION OR LABEL

Name
Gender
DOB (DD-Mon-YYYY) AHC/PHN
Phone
Email
Address
City
Province Postal Code

☐ Does the patient have Out of Province insurance?

Alternate/preferred contact person (ie for those with cognitive impairments)

PHYSICIAN INFO OR CLINIC STAMP/PRAC ID#

Referring MD
Practitioner ID #
Phone Number
Fax Number

Translator required? ☐ Yes ☐ No

If yes, put the language:

Family Doctor/Primary Care Provider (if different than Referring MD)

CONSULTATION REQUIRED

Geriatric Medicine

- ☐ Comprehensive geriatric assessment
- ☐ Cognitive assessment
- ☐ Behavioral and psychological symptoms of dementia
- ☐ De-prescribing/medication review/polypharmacy
- ☐ Preventative medicine in the older adult
- ☐ Sleep concerns
- ☐ Falls/mobility concerns
- ☐ Chronic pain
- ☐ Frailty
- ☐ Complex medical
- ☐ Other:

☐ **URGENT** ☐ **ROUTINE**

Geriatric psychiatry

☐ Reason for referral:

MSK/joint assessment and consideration for injection

☐ Hip ☐ Knee ☐ Shoulder

ADDITIONAL INFORMATION

Please attach the following

☐ Additional relevant history ☐ Updated medication list ☐ Copies of previous cognitive testing

Referrals may be triaged to either geriatric medicine or geriatric psychiatry based on the information provided