Interior Health

Seniors Health and Wellness Centre
Central Okanagan Referral Form

505 Doyle Ave 2nd Floor
Kelowna, BC
Phone: 250 469-7070 ext:13459
Fax: 250-469-7085
FAX FOR NEW REFERRALS: 250-980-1505

Kelowna SHWC Team: Clinic Physician, Geriatrician, Nurse Continenc
Advisor, Occupational Therapist, Pharmacist, Physiotherapist, Registere
Dietitian, Registered Nurse, Respiratory Therapist, Social Worker,
Speech Language Pathologist, Therapist Assistant

Services provided at this Centre:
- Comprehensive Geriatric Team Assessment
- Short Term Therapeutic Intervention
- Transitions in Care Planning at Discharge

Referred individuals must meet the following criteria:
- 65 years or older (under 65 by exception)
- Medically Complex (at risk of decline without interventions)
- Potential to stabilize/improve physical health & function
- Require a multi-disciplinary team approach
- Agreeable & able to attend multiple appointments

Please check all Geriatric Syndromes that apply:
☐ CSHS Clinical Frailty Scale of 4-6
☐ Sub-optimal pain control
☐ Unintentional weight loss/nutrition/hydration concerns
☐ Cognition (delirium, dementia, depression)
☐ More than 2 falls in the past year
☐ Incontinence &/or bowel & bladder concerns
☐ Medication concerns

Referral date:	PHN:	Date of birth: (MM/DD/YYYY)
Patient's name:	Pronouns if known:	Gender: ☐ M ☐ F ☐ non-binary
Patient's home address:		Home Phone #: Cell Phone:
Living situation: ☐ Alone ☐ With Family/others: _____ ☐ Other: _____		Language: _____ ☐ Interpreter needed

Key Contact (Patient has given consent to contact to arrange appointments): ☐ **Yes** ☐ **No** ☐ **Unknown**

Name: _____ Phone #: _____

Relationship: _____

Family Physician or Nurse Practitioner:

Name: _____ Date last seen: _____

Office phone #: _____ Fax #: _____

Other physicians/agencies involved: _____

Reason for Referral (Identify your specific request and/or concerns needing further assessment):

Please attach the following with the referral:

☐ Past Medical and Surgical History **(required)**
☐ Current Medications - include over-the-counter medications, vitamins and herbal remedies **(required)**
☐ Allergies **(required)**
☐ Recent LABS (within 6 months if available)
☐ ECG (within 6 Months)
☐ MOST (Medical Orders for Scope of Treatment)
☐ Cognitive Testing – SMMSE, MoCA, Clock Drawing (include documents if available)
☐ Pertinent Specialist Reports (if not on Meditech) i.e. Psychiatry, Neurology, Respiratory, Cardiology

***** PLEASE FAX COMPLETED FORM TO: CENTRAL INTAKE: (250) 980- 1505 ****