WISE PROGRAM
INITIAL MDT ASSESSMENT

Wellness for Independent Seniors Program (W.I.S.E.)

Phone: 416-323-6400 extension 8092
Fax: 416-323-7324

Geriatric Consultation Request

Date of Request:_____
(YYYY/MM/DD)

Physician Information:
Doctor: _____
Phone Number: _____
Address: _____
_____

Patient information:
Name: _____ DOB: (yyyy/mm/dd)
Address: _____
Phone Number: _____ HC #: _____

Next of Kin: _____ Relationship: _____
Phone: _____

***Reason for referral for geriatric assessment*:**

Concerns identified by: ☐ Patient ☐ Patient's Family ☐ Nurse ☐ Family Doctor ☐ Other: _____

CURRENT ISSUES/CONCERNS:

☐ A. Mobility Problems/Falls
☐ B. Activities of Daily Living
☐ C. Cognitive Impairment
☐ D. Possible Elder Abuse or Neglect
☐ E. Alcohol and other Substance Abuse
☐ F. Social Isolation
☐ G. Nutrition Concerns: _____
☐ H. Inadequate Family or Community Social Supports
☐ I. Difficulty with Current Living Situation
☐ J. Home Safety
☐ K. Mental Health Concerns
☐ L. Wandering
☐ M. Caregiver Burden
☐ N. Other _____

ADDITIONAL INFORMATION

Medical History:

Medications and Supplements (please list all current):

Social History:

Supports in home (eg Community Care Access Center):

Comments:

_____ _____ _____

Referring Physician's Name (please print clearly) Referring Physician's Signature Date (yyyy/mm/dd)

WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

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