MUSKOKA ALGONQUIN HEALTHCARE

Seniors Assessment and Support Outreach Team (SASOT) REFERRAL FORM

South Muskoka Memorial Hospital
75 Ann Street, Bracebridge, ON P1L 2E4
Telephone: (705) 645-4400 Ext. 3505
Fax: (705) 645-6372

PATIENT INFORMATION

Name: ______________________________________

Address: ______________________________________

Phone Number: ______________________________________

DOB: ______________________________________

Contact person if different from patient

Name: ______________________________

Relationship: ______________________________

Phone: ______________________________

PRIMARY REASON(S) FOR REFERRAL

(ie: functional, physical or cognitive decline; home safety; falls; medication safety; social issues such as caregiver burden, change in family dynamics, history of elder abuse - verbal, physical, sexual, financial, neglect, etc.) ****SECTION MUST BE COMPLETED BY REFERRING MD/NP***

☐ Functional, Physical, or Cognitive Decline

☐ Home Safety ______________________________

☐ Falls ______________________________

☐ Medication Safety ______________________________

☐ Social Issues ______________________________

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☐ **PRIORITY**

☐ **ROUTINE**

SUMMARY MEDICAL HISTORY AND MEDICATION LIST

☐ **ATTACHED**

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☐ **Potential risk of harm i.e. any history of mental health, alcohol or drug concerns.**

☐ **Any history of MRSA, VRE, C-Diff, TB, HIV, Hepatitis**

REFERRING PHYSICIAN OR NURSE PRACTITIONER

Name: ______________________________ Date: ______________________________

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