Ottawa Health Team
Équipe Santé Ottawa

Frail Older Adult Identification/Referral Form

*Red-starred fields are mandatory. Populating non-mandatory fields is encouraged but if left blank, we will obtain it via the patient interview.

Date of Referral*: MM / DD / YYYY Referral Source*: Email*:
Completed by*: Title*: Tel #*: Fax #:

Patient Consent Statement

"Patient is aware, agreeable, and consents to referral and sharing of the following information" * ☑ Yes

Patient Information

Preferred Pronoun:	**Preferred Name:**
Last Name*:	**First Name*:**
Date of Birth*: MM / DD / YYYY	**Health Card #:** If this is an IFH number (not OHIP), check here ☐

Patient Address:
City: Ottawa **Province:** ON **Postal Code:**
No fixed address: ☐ Living in Shelter ☐ On the street ☐ Other: _____

Patient's Preferred Phone #*:	**Patient's Alternate Phone #:**
Patient's Email:	**Sex (as indicated on official ID) *:** M ☐ F ☐ X ☐
Language of service*: English ☐ French ☐	**Interpreter Required** (specify language): ☐ _____

Contact Person (other than patient): **Relationship:** Spouse ☐ PoA ☐ Friend ☐
Phone #: **Alternate #:** Other ☐: _____
Email:

Patient's Primary Care

If Primary Care Provider is referral source, check here ☐

Primary Care Provider Name:
Designation: MD ☐ NP ☐ **N/A - Patient does not have a PCP** ☐

Contact Info & Clinic Location
Phone #: **Fax #:** **Email:**
Clinic Address:
City: Ottawa **Province:** ON **Postal Code:**

Reason for Referral*:

☐ I have deemed the patient to be **frail**, and at greater risk of adverse outcomes by reason of **their low household income** and **lack of social supports**.

Patient Frailty Score* - from the ***Rockwood Clinical Frailty Scale (CFS), 2020***
If unfamiliar, please consult "Top tips to help you use the clinical frailty scale" to ensure your assessment's validity.

Level 4 - Living with Very Mild Frailty ☐
This category marks early transition from complete independence. While not dependent on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up" and/or being tired during the day.

Level 5 - Living with Mild Frailty ☐
People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

Level 6 - Living with Moderate Frailty ☐
People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

SCORING FRAILTY IN PEOPLE WITH DEMENTIA: The degree of frailty generally corresponds to the degree of dementia. Refer to ***Rockwood CFS* (2020)**.

Level 7-9 patients are not currently in scope for this service. Consider a referral to PCO, CSS, home care and/or palliative care program as appropriate.

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Clinical and/or social support(s) that you believe would most improve this patient's trajectory:

1. _____
2. _____
3. _____

Patient's Frailty Factors (AVOID)

Immunizations*

Immunizations List	Immunization Date (MM/DD/YYYY)	Up-to-date?
1. Influenza (*high-dose if 65+, annual*)	Last Administered on:_____	☐
2. Shingles (*one-time*)	Last Administered on:_____	☐
3. Pneumococcal (*one-time*)	Last Administered on:_____	☐
4. Tetanus (*every 10 years*)	Last Administered on:_____	☐
5. Diphtheria (*every 10 years)*	Last Administered on:_____	☐
6. Pertussis (*one-time as adult*)	Last Administered on:_____	☐

Medication & Allergies*

Medication List

1._____ 7. _____
2._____ 8. _____
3._____ 9. _____
4._____ 10. _____
5._____ 11. _____
6._____ 12. _____

Date of last medication reconciliation (if unknown, leave blank): DD / MM / YYYY
Medication reconciliation requested: Yes ☐ No ☐

Known Allergies

1._____ 3._____.
2._____ 4._____

Social interaction and engagement

Does patient report feeling lonely? Yes ☐ No ☐ Don't know ☐

How often does patient interact with friends or family members?

At least... Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Seldom/Never ☐ Don't know ☐

Is patient a member of any organization(s) or interest group(s)? Yes ☐ No ☐ Don't know ☐
If Yes, please specify:_____

Physical Activity

How frequently does the patient engage in aerobic activity in an average week? (e.g., brisk walk/bike ride, gardening, dancing, taking stairs, swimming)

Very active ☐	**Moderately active** ☐	**Lightly active** ☐	**Sedentary** ☐
6-7x/week	3-5x/week	1-3x/week	Rarely or never

Favorite activities (if known):

_____ _____

Diet and Nutrition

Known barriers to healthy eating:

1._____ 3._____
2._____ 4._____

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Patient's Medical & Social History

Medical Problems*

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Contextual Factors*

☐Barriers to accessing transportation ☐Barriers to accessing phone/text ☐Barriers to accessing internet/email
☐Frequent no shows ☐Frequent ED visits, hospitalizations, primary care appointments, and use of services
☐Abuse (past, present) ☐Risks for general safety (e.g. falls) – specify: _____
☐Other (list all that apply): _____

Additional Comments:
_____
_____

Risks / Safety Precautions for Home Visits:

1. _____
2. _____
3. _____

Patient's Care Team (Known Service Providers) *

1. **Name of Service Provider:** **Occupation/Title:**
   Organization:
   Phone #: **Fax #:** **Email:**
2. **Name of Service Provider:** **Occupation/Title:**
   Organization:
   Phone #: **Fax #:** **Email:**
3. **Name of Service Provider:** **Occupation/Title:**
   Organization:
   Phone #: **Fax #:** **Email:**
4. **Name of Service Provider:** **Occupation/Title:**
   Organization:
   Phone #: **Fax #:** **Email:**
5. **Name of Service Provider:** **Occupation/Title:**
   Organization:
   Phone #: **Fax #:** **Email:**

Attach any relevant file(s) (e.g. geriatric assessment, consultant note, existing care plan):

☐
☐
☐
☐

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