Dementia Stabilization Program

Referral Form

Patient Label
(optional)

Consortia Health Care Inc.
2812 – 10360 102 Street NW   Edmonton, AB   T5J 0K6
Phone: (780) 851-9717   Fax: (780) 800-9941

ConsortiaCare.ca

Please fax form to: (780) 800-9941

***Alberta Blue Cross: Coverage for Seniors* eligibility will be confirmed upon receipt of referral.** Benefits eligible seniors *(age 65 or older)* are not responsible for the cost of nursing assessments, referrals or care planning.

URGENCY OF REFERRAL:	☐ **24-72 hours**	☐ **3-5 days**	☐ **7-14 days**

A. PATIENT INFORMATION

Last Name:	First Name:	Initial:	Gender : ☐ Male ☐ Female ☐ Other
Date of Birth:	Alberta Personal Health Number:		Patient Phone:
Patient's Home Address: *(suite/apartment, street address, city, postal code)*			
Primary Contact Name:	Primary Contact Phone:		Book Appointment With? ☐ Patient ☐ Primary Contact
Other Contact Information: *(communication barriers, preferred e-mail, etc.)*			

B. PROGRAM ELIGIBLITY CHECKLIST

- **Patient is experiencing Behavioural or Psychological Symptoms of Dementia (BPSD) resulting in an acute decline in function, frailty or failure to thrive in the community** ☐ Yes ☐ No
- **Patient lives within an independent living, lodge or home setting** ☐ Yes ☐ No
- **Patient or substitute decision-maker consents to referral** ☐ Yes ☐ No

C. PRESCRIPTION FOR HOME CARE *(Physician orders for home care required for Alberta Blue Cross coverage)*

Please provide transitional home care *(2 visits x 3 hours)* by a Registered Nurse (RN) to assess, support and manage geriatric syndromes in the patient's residence.

Physician Signature:	Date:

D. PRESCRIBER INFORMATION

Physician Name:	Clinic Name:	Most Responsible Provider? ☐ Yes ☐ No
Phone:	Fax:	E-mail:

E. REFERRAL COMMENTS / OTHER