

## Community Seniors Care Program Referral Form

**Client Information:**

**Date of Referral:**

**Family Physician:**

**Referred by:**

**Client aware of referral**  Yes  No

**Caregiver Name/Relation:**

**Caregiver Phone Number:**

**Best Person to contact:**

**PROGRAM REFERRAL CRITERIA:**

Age 65 or older **OR**  Age 55-64 and experiencing geriatric syndrome

**AND**

Frailty score 4-6 (CSHA Frailty Score, refer to page 2)

**Plus two or more of the following:**

- Recent onset of functional, physical or cognitive decline
- Major changes in caregiver support required/caregiver stress
- Polypharmacy
- Recent fall/fear of falls
- Two or more emergency department visits within the last 3 months
- Unintentional weight loss

**Geriatric Syndrome** can include any combination of the following:

- Incontinence
- Sleep problems
- Dementia
- Falls
- Weight Loss
- Malnourishment
- Depression
- Pain

**REASON FOR REFERRAL/BRIEF HISTORY OF CONCERNS:**

**REFERRING SOURCE: PLEASE IDENTIFY YOUR PRIMARY GOAL(S) FOR THIS REFERRAL:**

**Please include most recent lab results:**

CBC, Electrolytes, Vitamin B12, Ferritin, TSH, A1C, Cr (eGFR), Liver Panel, Lipids, Extended Electrolytes  
Drug levels (if applicable) – Digoxin, Lithium, Anticonvulsants

\*\*\*Please include a list of current medications with referral\*\*\*

**INTERNAL REFERRALS: PLEASE SEND COMPLETED REFERRALS AS A TASK TO THE CSCP TEAM**

**EXTERNAL REFERRALS: PLEASE FAX COMPLETED REFERRALS TO (705) 526-1205**

## Clinical Frailty Scale\*



**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



**2 Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



**3 Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



**4 Vulnerable** – 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.



**5 Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



**6 Moderately Frail** – People 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.



**7 Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



**9. Terminally Ill** - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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