Montfort

CHRONIC DISEASE MANAGEMENT
Reference document

Patient's identification

FOR ONTARIO RESIDENTS ONLY

PRIORITY (CHOOSE THE APPROPRIATE RANGE)

❑ 1-2 weeks ❑ 2-4 weeks

Fax referral to 613-688-1086

AT LEAST 2 COMORBIDITIES and/or	GERIATRIC PROBLEMS
❑ Chronic obstructive pulmonary disease (COPD)	
❑ Heart failure	❑ Mobility/falls
❑ Coronary disease	❑ Caregiver stress
❑ Atrial fibrillation	❑ Mood/Depression
❑ HTN	❑ Behaviours
❑ Diabetes	❑ Continence
❑ Chronic kidney disease (CKD)	❑ Pain
❑ Stroke	❑ Polypharmacy
❑ Cirrhosis	❑ Nutrition
❑ Cognitive impairment or dementia	❑ Function
❑ Other : _____	❑ Safety

SOCIAL HISTORY

❑ Smoking
❑ ETOH
❑ Drugs
❑ Lives alone
❑ Multiple admissions or visits in ER
❑ Other : _____

REASON FOR CONSULTATION

❑ Support with chronic conditions self-care ❑ Facilitate care transition to community
❑ Needs further geriatric assessment
❑ Advanced care planning
❑ Limited social support/isolation
❑ Mental health and/or sleeping disorders related to multimorbidity (anxiety, depression, adjustment disorder)
❑ Optimisation of the functional status
❑ Other : _____

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DATE : _____ TIME : _____

PHYSICIAN'S SIGNATURE:
_____