Geriatric Regional Assessment Team Referral Form

GRAT does not provide emergency services.
If your client needs immediate help, please direct them
to the nearest Emergency Department, or call 911.

Please fill out all pages enclosed.
For client privacy, please FAX completed referral to **206 737-0375**

Date _____

Client Name ___ Age _ DOB

Gender _____ Marital status _____ Partner Name _____

Primary Language _____ Interpreter Needed ☐Yes ☐No

Address _____ Is this a facility? ☐Yes ☐No

_____ Phone _____

Others in household _____
Client aware of referral ☐Yes ☐No

Anyone to call prior to visit for further information?

Name _____ Phone _____

Relationship _____

Presenting problem (Why refer now? Has something changed?)

This form should be completed by the approved providers.
Please do not share it without the consent from GRAT. Thank you.

Updated: 10/8/2021

Reason for referral

Imminent danger to self / others? ☐No ☐Yes Referred to _____

☐ Behavioral concerns ☐ Functional decline ☐ Mental Health Concerns
☐ Caregiver/Family issues ☐ Home Safety ☐ Multiple health issues
☐ Cognitive/Memory issues ☐ Incontinence ☐ Social isolation
☐ Falls / Frailty concerns ☐ Medication concerns ☐ Substance use concerns
☐ Tenuous living situation ☐ Unhealthy Environment ☐ Wandering
☐ Other: _____ Comments _____

Safety concerns for visiting team ☐ None

☐ Weapons ☐ Dogs ☐ Violence ☐ Contagious diseases ☐ Infestation concerns
☐ Other: _____ Comments

Referring source_____(pronouns) (____ | _____)

Relationship _____ Phone _____

Organization _____

Email: _____

Other People/Agencies Involved

Family / Support _____ Phone _____

POA ☐Unknown ☐No ☐Yes _____ Phone _____

Primary Physician _____ Phone _____

Mental Health CM / Agency _____ Phone _____

Other Person / Agency _____ Phone _____

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