Hôtel-Dieu Grace Healthcare -Tayfour Campus

GERIATRIC MENTAL HEALTH OUTREACH TEAM

(Formerly Mental Health Program for Older Adults)

Telephone 257-5105 Fax 257-5197

Community

Referral Form

SURNAME _____ **FIRST NAME** _____ **MARITAL STATUS**

GENDER ☐M ☐F ☐S ☐M ☐W ☐D ☐SEP

DOB: (D/M/Y) _____ **OHIP#** _____ **Version Code** _____

LANGUAGE(S) spoken _____

ADDRESS: Street _____ **City** _____ **Province ON Postal Code** _____

TELEPHONE # _____

CONTACT PERSON (With Whom to Arrange Visit) _____

Relationship to Client _____

Contact Telephone #'s _____

REFERRAL SOURCE (primary care physician/psychiatrist/or referring physician, if different than primary care physician): _____

Telephone # _____ **Fax #** _____

Address: Street _____ **City** _____ **, ON** **Postal Code** _____

PLEASE COMPLETE INFORMATION BELOW AND ATTACH REQUESTED REPORTS

PSYCHIATRISTS PLEASE ALSO COMPLETE PAGE 2

NOTE: Program does not provide ongoing psychiatric follow up following discharge

REASON FOR REFERRAL:

Admission Criteria: **At least 65 years or experiencing age related dementia/behavior issues**

Treatment has been attempted but patient has not responded to primary care

Provisional Diagnosis: _____

Duration of Current Symptoms: _____

_____

Past Treatment: _____

_____

Other Relevant Concerns: _____

_____

NAME OF PSYCHIATRIST (if one currently involved with client): _____

_____

Are there any known infestations in the client's environment that program staff should be aware of (ex. Bed bugs, lice, fleas, and scabies)? _____

Physician Signature: _____ **OHIP Billing Number:** _____

Form Completed by: _____ **Date of Referral:** _____

****PLEASE FORWARD MEDICAL/PSYCHIATRIC HISTORY, MEDICATION LIST, RECENT LAB RESULTS, and CT/MRI REPORTS AND RELEVANT CONSULTATIONS WITH SPECIALISTS****

Once all requested referral information has been received the referral will be processed.

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For Intake use only: **Previously Seen: No Yes Date:** _____ **Worker:** _____ **Psychiatrist:** _____

11. PLEASE ATTACH COPY OF ANY PSYCHIATRIC REPORT COMPLETED IN PAST SEVERAL YEARS.

12. LENGTH OF TIME AS CARE PROVIDER FOR THIS PATIENT: _____

13. PATIENT'S PRIMARY PSYCHIATRIC DIAGNOSIS AND CO-MORBIDITIES (INCLUDING ADDICITONS AND PAIN DISORDERS):

14. WHAT IS THE GOAL OF THIS REFERRAL? WHAT IS IT THAT YOU ARE EXPECTING TO BE ACCOMPLISHED?

15. WHAT MEDICATIONS HAVE BEEN TRIED AND WITH WHAT RESULTS? (IF NOT COMPLETE ON PREVIOUS PAGE)

16. WHAT TYPE OF PSYCHOTHERAPY HAS BEEN TRIED? (INDIVIDUAL, GROUP, SELF-HELP, ETC)

17. OUR PROGRAM DOES NOT PROVIDE ON-GOING PSYCHIATRY FOLLOW UP UPON PROGRAM COMPLETION AND AND PATIENT WILL BE RETURNED TO YOUR CARE. ARE YOU AGREEABLE TO THIS [ ] YES [ ] NO- IF NOT, WHY?