Community Referral Form

Geriatric Mental Health Outreach Team

Telephone: 519-337-5411 Fax: 519-337-2325

**\*A timely response from the psychiatrist requires the following to be attached:**

* Dementia Screen Blood Work ~CBC, BUN, Lytes, Liver Function, SED rate, Blood Sugar. Magnesium, Calcium, TSH, B12, Folate and Ferritin
* ECG & Urinalysis
* Current List of Medications – Please include over the counter and Homeopathic.
* Past Psychiatric or Specialist Consult Notes if available
* Any other relevant information

**Doctors Signature:**

**\*Required\* Referring Physician OHIP Billing Number:**

**\\**

**Family Doctor: Date of Referral:**

**Address:**

**Phone # Referral Source:**

**Fax #**

**\**Please be advised that the referral must come from the Family Physician and all referrals will be provided with an assessment and psychiatric consult\****

**CLIENT INFORMATION**

**Health Card #:**

**Version Code:**

Language of Origin:
Language Spoken:

**Person to contact to arrange assessment:** Name:

Relationship:

Phone #:

Is the Public Guardian & Trustee Involved? Yes [ ]  No [ ]  **Is there a SDM and or POA?** Yes [ ]  No [ ]  POA PC [ ]  POA P [ ]  BOTH [ ]  POA Enacted [ ]

Name and Contact Information:

Client Name:

DOB: / / Age:

 DD MM YYYY

Male [ ]  Female [ ]

Phone #:

Address:

Registered with the Alzheimer’s wandering registry? Yes [ ]  No [ ]

Is the client aware of the referral? Yes [ ]  No[ ]

**Marital Status:**

Single[ ]  Married[ ]  Common Law[ ]  Widow[ ]  Divorced[ ]  Separated[ ]

**Housing Status:**

House[ ]  Group home[ ]  Apartment[ ]  Rest Home[ ]  Retirement Home[ ]  Risk for Homelessness [ ]

**Living Arrangements:**

Alone[ ]  Partner[ ]  Caregiver[ ]

**Reason for Referral:**

**ER Visit in the last 30 Days:**

 **History of Dementia:** [ ]  Yes [ ] No [ ] Unknown **Type:**

 **Neurological Condition:** [ ] Yes [ ] No [ ] Unknown **Type**:

**Allergies:**

**Medical/Surgical History:**

**Other Medical Professionals Involved:**

**RISK FACTORS**

1. **Are they currently under the care of a Psychiatrist?** [ ] Yes [ ] No [ ] Unknown
**Name:**

**2. Is there an existing Mental Health Diagnosis?** [ ] Yes [ ] No [ ] Unknown
 **comments:**

**3.** **Is there an existing** **Substance Abuse Problem?** [ ] Yes [ ] No [ ] Unknown
 **comments:**

**4. Symptoms of Mental Illness present at this time:** [ ] Yes [ ] No [ ] Unknown

 **Please describe:**

**5. Thoughts of suicide:** [ ] Yes [ ] No [ ] Unknown
 **comments:**

**6. Past suicide Attempts:** [ ] Yes [ ] No [ ] Unknown
 **comments:**

**7. Concerns with medication compliance:** [ ] Yes [ ] No [ ] Unknown
 **comments:**

**8. Other concerns or risks:**  [ ] Yes [ ] No [ ] Unknown

 (i.e., weapons, animals, bed bugs, hoarding, criminal history, etc.)

**SERVICES IN PLACE**

[ ] Alzheimer Society [ ] BSO Case Manager- CCAC [ ] CMHA [ ] Crisis Intervention

[ ] Dual Diagnosis [ ] GMHOT [ ] Respite [ ] Rest Home [ ] Addiction Services

[ ] Retirement Home [ ] Veteran’s Affairs [ ] None [ ] Other [ ] Unknown

[ ] Community Living

[ ] Other Community Social Service(s)