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)