Long Term Care Home Geriatric Mental Health Outreach Team (GMHOT) Referral Form

Tel: 519-337-5411 Fax: 519-337-2325

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

- Dementia Screen Blood Work ~CBC, Lytes, Liver Function, Blood Sugar, Magnesium, Calcium, TSH, B12, 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.

Primary Care Signature: ______________________

Referring Primary Care OHIP Billing Number: ______________________

Primary Care Provider: ______________________

Address: ______________________

Phone Number: ______________________

Fax Number: ______________________

Date of Referral: ______________________

Referral Source: ______________________

Referrals must come from the Primary Care Provider.

All referrals will be provided with an assessment by GMHOT staff and psychiatric consult.

Reason for Referral: ______________________

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CLIENT INFORMATION

Client Legal Name: ______________________

Preferred Name: ______________________

Pronoun: ______________________

DOB: ____ / ____ / ____ (DD MM YYYY) Age: ______

Phone Number: ______________________

Address: ______________________

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Health Card #: ______________________

Version Code: ______________________

Language of Origin: ______________________

Language Spoken: ______________________

Is there a SDM or a POA? Yes ☐ No ☐

POA PC ☐ POA P ☐ BOTH ☐ POA Enacted ☐

Name & Contact Info: ______________________

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Please confirm client/POA has provided consent for referral. Yes ☐

Long Term Care Home Admission Date: ______________________

ER Visit in the last 30 days: ______________________

June 2024

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Medical / Surgical History: ______________________________

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Other Medical Professionals Involved -or- Referrals in Process: ______________________________

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RISK FACTORS:

1. Are the client 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 ☐

   Please describe: ______________________________

4. Symptoms of Mental Illness present at this time: Yes ☐ No ☐ Unknown ☐

   Comments: ______________________________

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 ☐

   Comments: ______________________________

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

June 2024