WEST PARK HEALTHCARE CENTRE

SENIORS MENTAL HEALTH SERVICE
REFERRAL FORM
TELEPHONE: (416) 243-3732
FAX: (416) 243-3735

FOR INTERNAL USE ONLY:
Date of Referral: ________________ SMHS Chart #: ________________________
☐ New Admission ☐ Reassessment Consultant: ________________________
Contact Date: ____________________ Appt. Date: ________________________

CLIENT/PATIENT NAME: ____________________ **HEALTH CARD** #:____________________

ADDRESS: ____ **APT. #:** ______________

____ **POSTAL CODE**: ____________________

HOME PHONE #: _________________________ **D.O.B. (D-M-Y):** ______________________

GENDER: ☐ M ☐ F **MARITAL STATUS**: Mar ☐ Wid ☐ Div ☐ Sep ☐ Sngl ☐

CONTACT PERSON: ________________________ Home Phone #: ______________________
Relationship: ______________________________ Business Phone #: ___________________

FAMILY DOCTOR: ______________________ **AWARE OF REFERRAL**? ☐ Y ☐ N
Address: ____
Telephone: ___________________________________ Fax: ____________________________

REFERRING SOURCE:
Agency/relationship: ______________________________ Telephone: ________________________
Address: _______________________________________ Fax: ____________________________

REASON(S) FOR PSYCHOGERIATRIC CONSULTATION:

☐ Memory impairment
☐ Depression/grief
☐ Anxiety
☐ Suspiciousness/Delusions
☐ Hallucinations
☐ Verbal aggression
☐ Sexually inappropriate behaviour
☐ Hoarding/Rummaging

☐ Safety concerns:
- ☐ Suicide Threat/Attempt
- ☐ Wandering
- ☐ Violence
- ☐ Medication misuse
- ☐ ↓ self-care
- ☐ Other _____________

☐ Elder abuse:
- ☐ Physical
- ☐ Psychological
- ☐ Financial

☐ Caregiver stress
☐ Marital/family conflict
☐ Other ______________

COMMENTS:

____
____
____
____

MEDICAL/PSYCHIATRIC INFORMATION

Current Med/Psych Diagnoses: ____

____

Current Medications:	Dosage:	Date Prescribed:
________________	________________	____________
________________	________________	____________
________________	________________	____________
________________	________________	____________
________________	________________	____________
________________	________________	____________
________________	________________	____________

PREVIOUS CONSULTS: Psychiatry Geriatrics Neurology Other __________

Specialists' Names: ____
Please attach relevant consult notes and imaging reports/recent lab findings.

ADDITIONAL INFORMATION

Client Aware of Referral: ☐ Yes ☐ No

Hearing impaired: ☐ Yes ☐ No Device needed: ☐ Yes ☐ No

Interpreter needed: ☐ Yes ☐ No Lanuage: ________________________

Living arrangement: ☐ alone ☐ spouse ☐ adult child ☐ other relative ☐ institution
☐ other ____________________

Support Services/Agencies presently involved:

- ☐ CCAC:
  - ☐ Homemaker
  - ☐ RN/RPN
  - ☐ OT/PT
  - ☐ Social Work
  - ☐ Other ______________
- ☐ Meals on Wheels
- ☐ Adult Day Program: ______________
- ☐ Supportive Housing: ______________
- ☐ Other Agencies: ________________

FOR INTERNAL USE ONLY

REFERRAL OUTCOME:
Case Status: ☐ Open ☐ Re-open ☐ Non-Admit (Reason: ____________________)

TIME FRAME: Date Discussed: ______________ Report Sent: ________________