West Park HEALTHCARE CENTRE — get your life back

Referral Form For Psychogeriatric Outreach Services

To ensure your referral is processed promptly, please complete ALL sections.

Fax To: 416-243-3735

CLIENT INFORMATION

Health Card #					Version Code
Last Name			First Name		
Street Number and Address			City, Prov		Postal Code
Phone	Marital Status	Date of Birth	Year	Month	Day
☐ Male	☐ Female	☐ Other	Preferred Language – Please Specify		
Client Aware of Referral?	☐ Yes	☐ No	Family Aware of Referral?	☐ Yes	☐ No

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ Specific Symptoms of Serious Mental Illness	☐ Behavioural Issues	☐ Social Isolation
☐ Depression	☐ Violent Tendencies	☐ Home Safety Concerns
☐ Suicidal / Self Harm	☐ Housing Issues	☐ Require Diagnostic Assessment
☐ Cognitive Decline	☐ Relationship/Caregiving/Social Issues	☐ Psychiatric Medication Review
☐ Substance Abuse/Addictions	☐ Legal/Financial Issues	☐ Abuse – Please Specify
Other – Please Specify		

CLIENT'S MEDICAL/PSYCHIATRIC STATUS

☐ Stable	☐ Recent/Acute Changes – Please Specify	☐ Psychiatric Diagnosis – Please Specify	
If Client Has a Psychiatrist:	Last Name	First Name	Phone

CONTACT PERSON

Relationship to Client:	☐ Family – Please Specify	☐ Power of Attorney for Personal Care / SDM	☐ Other – Please Specify
Last Name		First Name	
Home Phone	Work Phone	Cell Phone	

CLIENT'S LIVING ARRANGEMENTS

☐ Lives Alone	☐ Lives With – Please Specify			
Lives In:	☐ Private Home/Apt.	☐ Long-Term Care Facility (Nursing Home)	☐ Supportive Housing	☐ Retirement Home
☐ Other – Please Specify				
☐ Potential Safety Risks for Home or Office Visits – Please Specify				

REFERRER INFORMATION

Referrer:	☐ Family Physician	☐ Specialist	Billing Number
☐ Family/Caregiver	☐ Self	☐ Power of Attorney for Personal Care / Substitute Decision Maker (SDM)	☐ Hospital
☐ Agency – Please Specify		☐ Other – Please Specify	
Last Name		First Name	
Street Number and Address		City, Prov	Postal Code
Phone	Ext.	Fax	

FAMILY PHYSICIAN INFORMATION (IF NOT THE REFERRER)

Last Name	First Name	Phone

<<< Please include relevant/recent consult notes, blood work, etc. >>>

Referrer's Signature:	Date of Referral:

[Rev: Jan 28, 2010]

SENIORS MENTAL HEALTH SERVICE

REFERRAL FORM
TELEPHONE: (416) 243-3732
FAX: (416) 243-3735

CLIENT NAME: ____

DATE: ______________________________

ADDITIONAL INFORMATION ON REASONS FOR REFERRAL:

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FOR INTERNAL USE ONLY:	
Date of Referral:	SMHS Chart #:
□ New Admission □ Reassessment	Consultant:
Contact Date:	Appt. Date: