

Geriatric Psychiatry Specialty Clinic Referral Form Mental Health and Addictions

Telephone: 905-378-4647 Ext. 49614 Fax: 905-704-4420

Date of Referral: (dd/mm/yyyy) _____

Name: _____

Address: _____

City: _____ Postal Code: _____

Telephone Number: _____

Cell Phone Number: _____

Date of Birth: _____ (dd/mm/yyyy)

Age: _____ Gender: Male Female Transgender Male Transgender Female

Health Card Number: _____

Marital Status: Single Married/Common Law Separated/Divorced Widow/Widower Other: _____

Client/Caregiver Informed of Referral? Yes No

Client living with: _____

Caregiver / Next of Kin: _____

Caregiver / Next of Kin Phone Number: _____

Referred by: _____

Phone Number: _____

Family Physician: _____

Telephone Number: _____

Psychiatrist: _____

Telephone Number: _____

Type of Housing: _____

Relationship: _____

Cell Phone Number: _____

Contact Person for Appointment: Client Caregiver/Next of Kin

Reason for Referral / Psychiatric Issue / Behaviour: _____

Medications / dosages (if needed, submit separate sheet): _____

Allergies: _____

Medical / Psychiatric History (if needed, submit separate sheet): _____

In order to facilitate our assessment, and prior to the booking of an appointment for new patients, please fax to our office any relevant investigations (i.e. diagnostic imaging, blood work, urinalysis, ECG, bone mineral density) and any previous consultations (i.e. neurology, psychiatry) and an up-to-date medication list.

Printed Physician Name

Physician Signature

OHIP Billing Number

Date (dd/mm/yyyy)



REF21

Chart Copy – Do Not Destroy

Geriatric Psychiatry Specialty Clinic Referral Form Mental Health and Addictions

Telephone: 905-378-4647 Ext. 49614 Fax: 905-704-4420

Psychosocial (check all that apply)					
Mood					
<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Angry	<input type="checkbox"/> Euphoric		
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Thoughts of Harming Others	<input type="checkbox"/> Other (specify): _____			
Screen	Score	Date (dd/mm/yyyy)	Screen	Score	Date (dd/mm/yyyy)
GDS			Cornell		
Behaviour					
<input type="checkbox"/> Agitation	<input type="checkbox"/> Aggression –Physical	<input type="checkbox"/> Aggression –Verbal			
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Wandering	<input type="checkbox"/> Disinhibited			
<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Rummaging	<input type="checkbox"/> Hoarding			
<input type="checkbox"/> Vocalizing	<input type="checkbox"/> Sundowning	<input type="checkbox"/> Insomnia			
<input type="checkbox"/> Resisting Care					
Thought Disturbance					
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Delusional			
Substance Use					
<input type="checkbox"/> Tobacco	<input type="checkbox"/> ETOH	<input type="checkbox"/> Other (specify): _____			
Has the patient been to a Treatment Program		<input type="checkbox"/> Yes, complete →	Date (dd/mm/yyyy): _____		
		<input type="checkbox"/> No	Site: _____		
Cognitive Status					
Is patient impaired?		<input type="checkbox"/> Yes, complete →	<input type="checkbox"/> Judgement impaired		
		<input type="checkbox"/> No	<input type="checkbox"/> Insight impaired		
			<input type="checkbox"/> Executive dysfunction		
Screen	Score	Date (dd/mm/yyyy)			
Standardized Mini Mental State Examination (SMMSE)					
Montreal Cognitive Assessment (MoCA)					
Communication impaired?					
<input type="checkbox"/> Normal	<input type="checkbox"/> Expressive	<input type="checkbox"/> Receptive	<input type="checkbox"/> Other (specify): _____		
Associated Changes:					
<input type="checkbox"/> No Change					
<input type="checkbox"/> Sleep / Rest Pattern					
<input type="checkbox"/> Appetite					
<input type="checkbox"/> Weight					
<input type="checkbox"/> Energy Level					
<input type="checkbox"/> Interests / Activities					
<input type="checkbox"/> Functional Ability (specify): _____					
Attach:					
<input type="checkbox"/> Copies of relevant consultations					
<input type="checkbox"/> Medication profile (length of time on medication)					
<input type="checkbox"/> PT / OT / SW / Nursing and Physician Progress Notes					
<input type="checkbox"/> Behaviour > Mood Observation Tracking / Summary					

Rev. 12/2016(v4)



REF21