St. Joseph's Healthcare Hamilton

REFERRAL FORM
Seniors Mental Health Outreach Services
Community

□ Halton Geriatric Mental Health Outreach Program
5230 South Service Road
Burlington, Ontario L7L 5K2
Tel: 905-681-8233 Toll Free: 1-866-429-7677 **Fax: 905-681-8628**

□ Trillium Health Center- West Toronto
150 Sherway Drive- 4th Floor
Toronto, Ontario M9C 1A4
Tel: 416-521-4006 **Fax: 416-521-4020**

Referral Date: (DD/M/YYYY)_____ Reg/UID#: _____(internal use only)

Client Name: _____ □ M □ F
Surname *First Name*

Address: _____
Street Number and Name *Apt or Unit #* *City* *Postal Code*

Phone Number: ( ) - _____ Alternate: ( ) - _____ Marital Status: _____

DOB: (DD/M/YYYY) _____ Age: _____ Health Card # : _____ / _____ / _____ VerCode: _____

Living With: □ Alone □ Spouse/Partner □ Family □ Other _____ Preferred Language: □ English □ Other: _____ Interpreter Needed? □ Yes

Person to contact for booking appointment: □ Client □ Caregiver/Next of Kin _____ Relationship: _____

Phone: ( ) - _____ Alternate: ( ) -_____

Is the referred client currently hospitalized? □ No □ Yes If yes, hospital name: _____ Discharge Date: _____
Has the referred person consented to the referral? □ Yes □ No
If person not capable, has the POA- PC or SDM consented to referral? □ Yes □ No Name of POA-PC/SDM: _____

Reason for Referral - Please check all that apply.

□ Diagnosis □ Medication Review □ Polypharmacy □ Substance Abuse/Addiction	□ Depression □ Mania □ Suicidal Ideation □ Anxiety	□ Hallucinations □ Delusions □ Paranoia/Suspiciousness □ Acute Confusion	□ Cognitive Decline □ Behaviour □ Risk to Others □ Agitation	□ Wandering □ Falls □ Hoarding □ Self Neglect	□ Sleep Disturbance □ Caregiver Stress □ Elder Abuse
□ I am referring the above senior to the Cognitive Behavioural Therapy (CBT) Group for older adults with depression offered by St. Joseph's					

Please summarize clearly your reason for the referral:

_____

_____

_____

Potential safety concerns for Assessor going into home:	□ UnKnown	□ Pets in Home	□ Infectious Condition	□ Smokers in Home	□ Isolated
	□ Firearms/Weapons	□ Others In Home	□ Environment (pests, damage, neglect, etc.)		

Please attach the following, if available:

Medical/Psychological/Psychiatric History □ Attached
Relevant Hospital Discharge Summaries □ Attached
Previous Investigations (e.g. EEG, EKG, CT/MRI, Echo etc) □ Attached
Current Medications – please attach a list □ Attached

** Current (within 3 months) Test / Lab Results including: CBC, GBCL (Glucose, Creatine, Lytes), TSH, Vitamin B12 level, Liver Function, Urea, Calcium, Albumin, therapeutic blood level for monitoring for valproic acid, carbamazepine, Lithium (as applicable) and Urinalysis.

Referral Source: _____ Referral Source Phone: ( ) - _____

Name of Family Physician: _____

Family Physician Phone: ( ) - _____ Family Physycian Fax : ( ) - _____

Family Physycian Signature: _____Date:_____
OHIP BILLING NUMBER

Please fax the above completed referral form, relevant notes, recent labs etc. to the appropriate program.