Providence Care **BEHAVIOURAL SUPPORT SERVICES**

PERSONAL HEALTH INFORMATION

SENIORS MENTAL HEALTH OUTREACH REFERRAL

Kingston	Hastings Prince Edward	Frontenac, Lennox & Addington
Phone: 613-384-9088	Phone: 613-771-0133	Phone: 613-354-3916
Fax: 613-384-6107	Fax: 613-771-0916	Fax: 613-354-6673

Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral.

CLIENT INFORMATION

Client Surname:

Given Name:

☐ M ☐ F

Health Card Number: **Version**

Date of Birth YYYY / MM / DD

Age:

Language: ☐ English
Other: ____________ Please specify

French Language Services Required? ☐ **Yes** ☐ **No**

Interpreter ☐ Family ☐ Professional ☐ Staff ☐ Volunteer
Format ☐ Written ☐ Verbal ☐ Both

Current Address:

Street Number Street Name

City Province Postal Code

Telephone Number *(please include area code)*

Currently in:
☐ Hospital ☐ Respite ☐ LTC

Facility Name:
Admission Date: YYYY / MM / DD

Client's Living Arrangements at the time of referral:
☐ Alone ☐ With Relative ☐ With Non-relative
☐ Other ☐ Unknown

Client to be seen at following location:
☐ At Home ☐ In Hospital ☐ At Clinic ☐ Other ____________

Contact Person: ____________ **Relation to Client:** ____________

Telephone Numbers: *(please include area code)*
Home: ____________ Work: ____________ Cellular: ____________

Community Supports:
☐ CCAC ☐ Geriatric Medicine ☐ Respite/Day Program ☐ Other

Has Client previously been seen by the Program?
☐ No ☐ Yes When: ____________

RISK BEHAVIOURS

Behaviour	Yes	No	Behaviour	Yes	No	Behaviour	Yes	No
Memory	☐	☐	Fires	☐	☐	Mood Change	☐	☐
Verbal Aggression	☐	☐	Weapons	☐	☐	Suicidal	☐	☐
Physical Aggression	☐	☐	Driving Concerns	☐	☐	Disturbed Sleep	☐	☐
Suspiciousness	☐	☐	Alcohol/Drugs	☐	☐	Appetite Changes	☐	☐
Agitation	☐	☐	Sexual Disinhibition	☐	☐	Caregiver Issues	☐	☐
Wandering	☐	☐	Self Neglect	☐	☐	Recent visit to ER	☐	☐

Reason for Referral *(What question or concern would you like to see addressed by the program?)*

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HISTORY & CURRENT STATUS

Sensory Loss:			**Mobility Status**		
Vision	☐ Yes	☐ No	☐ No problems	☐ Wheelchair	☐ Other:
Hearing	☐ Yes	☐ No	☐ Walker/Cane	☐ Housebound	

Current Medications: *(If available, please attach a copy of Client's Medication Administration Record)*

Allergies: ☐ Yes: ☐ No ☐ Unknown

Medical Problems: (*Please attach copies of any recent lab results, imaging, and/or relevant Consultation Notes)*

Psychiatric History: (*Please attach previous Psychiatric Consultation and/or Discharge Summaries)*

Client has been informed of Referral?: ☐ Yes ☐ No: *(please explain if "No")* ______________________

Name of Person Referring Client

Name of Referring Source: *(Please Print)*	Date Referral was Completed: YYYY / MM / DD	Signature of Referring Source:

Telephone Number: *(please include area code)*	Fax Number: *(please include area code)*

Family Physician Consent: (Only complete if referral source **is NOT** the Family Physician. The client's Family Physician **MUST** give consent for this referral.)

Physician Name:	Telephone Number: *(please include area code)*	Fax Number: *(please include area code)*

Consent of Family Physician obtained by: *(please print name)*	Agency / Institution affiliated with:

Please complete and fax to the appropriate office in your area as per the listing at located at the top of this form

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REFERRAL CRITERIA

Referrals are typically initiated by primary care clinicians (ie. family physicians or nurse practitioners). Other potential referral sources should review the referral with the primary care provider prior to referral. Patient criteria include late-onset degenerative dementias (i.e. Alzheimer's disease, other similar dementia) with onset at any age, and older adults (age 65 or greater) with late-onset of other psychiatric disorders such as depression, bipolar disorder, anxiety disorders, and psychotic disorders. Individuals not clearly meeting these criteria may be considered on a case by case basis.

TYPE OF SERVICE

Provides inter-professional outpatient services for dementia and other mental health conditions. Services typically include assessment by a seniors mental health case manager and consultation with a psychiatrist. Service provision typically includes consultation and may include short-term follow-up. Patients need to be able to attend one or more visits at Providence Care Hospital, for those unable to attend the hospital in person other programs within seniors mental health may be considered.