

HOSPITAL MENTAL HEALTH INPATIENT REFERRAL

Fax referral to Providence Care Central Intake 613-548-5595
Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral

ADULT MENTAL HEALTH (AMH) SENIORS MENTAL HEALTH (SMH)

Please note: we are not a crisis or emergency service
If you feel that your patient is too ill to tolerate the wait for an assessment/admission, please consider accessing a psychiatric crisis service or emergency room at the nearest hospital serving your patient's community.

CLIENT/PATIENT DEMOGRAPHICS

Name: _____ Gender: Male Female Other: _____
 Address: _____ Marital Status: Unknown
 Telephone: _____ Married Common-law Separated
 Permission to Leave Voicemail Yes No Divorced Widowed Single/Never married
 Date of Birth (YYYY/MM/DD): _____
 Health Card#: _____

FRENCH LANGUAGE SERVICES

Client/patient speaks/understands English: Yes No Interpreter Required Yes No
 Other languages spoken: _____

ALTERNATE CONTACT

Name: _____
 Power of Attorney (POA)/Substitute Decision Maker (SDM): _____
 Spouse: _____
 Other: _____
 Telephone: _____
 Permission to Leave Voicemail Yes No

REASON FOR REFERRAL/FACTORS CONTRIBUTING TO CURRENT REFERRAL (please include environmental stressors):

<input type="checkbox"/> Inability to care for self due to mental illness	<input type="checkbox"/> Medication review and stabilization	<input type="checkbox"/> Behavioural and psychological symptoms associated with dementia
<input type="checkbox"/> Poor functioning in community	<input type="checkbox"/> Substance misuse	<input type="checkbox"/> Threat or danger to self
<input type="checkbox"/> Self harm/Suicide	<input type="checkbox"/> Threat or danger to others	<input type="checkbox"/> Symptoms of mood
<input type="checkbox"/> Symptoms of anxiety	<input type="checkbox"/> Symptoms of psychosis	<input type="checkbox"/> Signs of cognitive impairment

Other: _____

PSYCHIATRIC DIAGNOS(E)S:

MEDICAL DIAGNOS(E)S (IF KNOWN OR SUSPECTED):

ALLERGIES:

HOSPITAL MENTAL HEALTH INPATIENT REFERRAL

RISKS			
<input type="checkbox"/> Medication non-adherence	<input type="checkbox"/> Alcohol misuse	<input type="checkbox"/> Tobacco/Nicotine use	
<input type="checkbox"/> Gambling	<input type="checkbox"/> Choking/aspiration/dysphagia	<input type="checkbox"/> Living alone	
<input type="checkbox"/> Physical/verbal aggression	<input type="checkbox"/> Sexual aggression	<input type="checkbox"/> Sexual disinhibition	
<input type="checkbox"/> Agitation	<input type="checkbox"/> Weapons	<input type="checkbox"/> Falls: If yes, describe functional mobility/assistive devices:	
<input type="checkbox"/> Arson/fire setting	<input type="checkbox"/> Wandering/elopement		
<input type="checkbox"/> Drug misuse	<input type="checkbox"/> Eating disorders		
<input type="checkbox"/> Street drugs <input type="checkbox"/> Prescription <input type="checkbox"/> Other:			
LEGAL STATUS/MENTAL HEALTH ACT			
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Involuntary	<input type="checkbox"/> Form#: _____	Expiry Date: <u>YYYY/MM/DD</u>
			<input type="checkbox"/> Contesting involuntary form
<input type="checkbox"/> Community Treatment Order	Expiry Date: <u>YYYY/MM/DD</u>	Pending Charges: <input type="checkbox"/> Yes <input type="checkbox"/> No	
CAPACITY TO CONSENT			
Capable to Consent to Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If no, please identify Substitute Decision Maker (SDM)/			
Power of Attorney (POA)/ Public Guardian & Trustee (PG&T): Name: _____ Phone Number: _____			
Capable to Manage Property: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If no, please identify Substitute Decision Maker (SDM)/			
Power of Attorney (POA)/ Public Guardian & Trustee (PG&T): Name: _____ Phone Number: _____			
Form 33 Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: <u>YYYY/MM/DD</u>			
FUNCTIONAL ABILITIES			
Personal Hygiene:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs prompts	<input type="checkbox"/> Needs assistance
Special Senses:	<input type="checkbox"/> Visual impairment	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Wheelchair/walker
Ambulation:	<input type="checkbox"/> Walks without assistance	<input type="checkbox"/> Walks with assistance	<input type="checkbox"/> Unsteady
Eating:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs prompts	<input type="checkbox"/> Needs assistance
Sleep:	<input type="checkbox"/> Normal	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Daytime sleeper
Communication:	<input type="checkbox"/> Receptive dysphasia	<input type="checkbox"/> Expressive dysphasia	
Income Sources (please specify): <input type="checkbox"/> ODSP <input type="checkbox"/> OAS <input type="checkbox"/> CPP <input type="checkbox"/> VAC <input type="checkbox"/> Other:			
COLLATERAL INFORMATION (please attach)			
<input type="checkbox"/> Admission/discharge summaries	<input type="checkbox"/> Diagnostic imaging	<input type="checkbox"/> Consultations	<input type="checkbox"/> Lab values
<input type="checkbox"/> Psychological assessments	<input type="checkbox"/> Functional assessments	<input type="checkbox"/> Psychosocial assessment	<input type="checkbox"/> Nursing notes
<input type="checkbox"/> Cognitive testing (MMSE/MOCA)	<input type="checkbox"/> ER notes/assessments	<input type="checkbox"/> Psychiatric Assessments	
<input type="checkbox"/> Medication list/Medication Administration Record (MAR)			
<input type="checkbox"/> Plan of care must be attached for intake assessment and determination of eligibility			

**HOSPITAL MENTAL HEALTH
INPATIENT REFERRAL**

<p>CURRENT LOCATION AT TIME OF REFERRAL</p> <p><input type="checkbox"/> Private House/Apt. <input type="checkbox"/> Retirement Home/Senior's Residence <input type="checkbox"/> Long Term Care Facility/Nursing Home <input type="checkbox"/> Acute Mental Health Care – Inpatient <input type="checkbox"/> Setting for persons with intellectual disabilities <input type="checkbox"/> Mental health residence (eg. psychiatric group home) <input type="checkbox"/> Other: _____</p>
<p>REFERRING PHYSICIAN/PSYCHIATRIST/NURSE PRACTITIONER</p> <p>Name: _____ Phone: _____</p>
<p>Primary Health Care Provider (if different from above)</p> <p>Name: _____ Phone: _____</p>
<p>Community Agency/Resources Involved (past or present):</p> <p>_____</p>
<p>THIS SECTION MUST BE COMPLETED BY THE REFERRING PSYCHIATRIST</p> <p>Referral Completed By (please print): _____ Signature: _____ Agency Name: _____ Phone: _____ Fax: _____</p> <p>DATE OF REFERRAL: <u>YYYY/MM/DD</u> Client/SDM aware of referral: <input type="checkbox"/> Yes <input type="checkbox"/> No Client/SDM agrees to referral: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>OFFICE USE ONLY</p> <p>Date Referral Received: <u>YYYY/MM/DD</u> Date Declined: <u>YYYY/MM/DD</u> Date Accepted: <u>YYYY/MM/DD</u> MRN#: _____ Date Referral Pre Registered: <u>YYYY/MM/DD</u> Date Admitted: <u>YYYY/MM/DD</u></p>

HOSPITAL MENTAL HEALTH INPATIENT REFERRAL

ADULT MENTAL HEALTH

Admission Criteria: 16 years of age or older, medically stable with a primary diagnosis of severe mental illness as defined by DSM V Axis 1 such as Schizophrenia, Schizoaffective Disorder, Mood Disorders such as Bipolar I or II or a Major Depressive Disorder, that requires complex aftercare, relapse prevention and/or specialized treatment or diagnostic procedures. Clients with a primary diagnosis of Developmental Delay, Substance Abuse, Personality Disorder, Psychosexual Disorder, Neurological Illness, Adjustment/Conduct Disorder, Eating Disorder or Brain Injury may be considered if there is strong suggestion of a comorbid Axis 1 diagnosis, but only for the purposes of assessment and stabilization. A letter that commits to accept the client back to the referring facility is a condition of acceptance of these individuals.

Outpatients serviced by Providence Care, Mental Health Services or other specialized community mental health services, whose treatment history is well-known to Providence Care who are relapsing, may be admitted directly with approval of the program.

Admission for social and/or financial reasons would not be considered appropriate.

Type of Service: Provides specialty mental health services to clients with serious and persistent mental illness who cannot be managed within the existing array of first line and intensive services.

SENIORS MENTAL HEALTH

Admission Criteria: Older patients, usually over 65 with dementia, experiencing severe and frequent responsive behaviors or age-related psychological symptoms that cannot be managed in their current setting. Medical comorbidities must be stable and consent from patient or substitute decision maker is required unless patient is being admitted under the Mental Health Act.

Type of Service: Provides inter-professional assessment, diagnosis, rehabilitation and stabilization to older patients with behavioral disturbances related to dementia that require high intensity support.