St. Joseph's Healthcare Hamilton

REFERRAL FORM
Seniors Mental Health Outreach Services
Community

Trillium HEALTH CENTRE

□ 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 Centre- West Toronto
150 Sherway Drive- 4th Floor
Toronto, Ontario M9C 1A5
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	□ Depression	□ Hallucinations	□ Cognitive Decline	□ Wandering	□ Sleep Disturbance
□ Medication Review	□ Mania	□ Delusions	□ Behaviour	□ Falls	□ Caregiver Stress
□ Polypharmacy	□ Suicidal Ideation	□ Paranoia/Suspiciousness	□ Risk to Others	□ Hoarding	□ Elder Abuse
□ Substance Abuse/Addiction	□ Anxiety	□ Acute Confusion	□ Agitation	□ Self Neglect	
□ 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, 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 Physlcian Fax : ( ) - _____

Family Physlcian Signature: _____Date:_____

OHIP BILLING NUMBER

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