Referral Form For Psychogeriatric Outreach Services

To ensure your referral is processed promptly, please complete ALL sections.

Fax To: 416-243-3735

CLIENT INFORMATION

Health Card #				Version Code	
Last Name		First Name			
Street Number and Address		City, Prov		Postal Code	
Phone	Marital Status	Date of Birth	Year	Month	Day
☐ Male ☐ Female	☐ Other	Preferred Language – Please Specify			
Client Aware of Referral? ☐ Yes ☐ No		Family Aware of Referral? ☐ Yes ☐ No			

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ Specific Symptoms of Serious Mental Illness	☐ Behavioural Issues	☐ Social Isolation
☐ Depression	☐ Violent Tendencies	☐ Home Safety Concerns
☐ Suicidal / Self Harm	☐ Housing Issues	☐ Require Diagnostic Assessment
☐ Cognitive Decline	☐ Relationship/Caregiving/Social Issues	☐ Psychiatric Medication Review
☐ Substance Abuse/Addictions	☐ Legal/Financial Issues	☐ Abuse – Please Specify

Other – Please Specify

CLIENT'S MEDICAL/PSYCHIATRIC STATUS

☐ Stable	☐ Recent/Acute Changes – Please Specify	☐ Psychiatric Diagnosis – Please Specify	
If Client Has a Psychiatrist:	Last Name	First Name	Phone

CONTACT PERSON

Relationship to Client:	☐ Family – Please Specify	☐ Power of Attorney for Personal Care / SDM	☐ Other – Please Specify
Last Name		First Name	
Home Phone	Work Phone	Cell Phone	

CLIENT'S LIVING ARRANGEMENTS

☐ Lives Alone ☐ Lives With – Please Specify

Lives In: ☐ Private Home/Apt. ☐ Long-Term Care Facility (Nursing Home) ☐ Supportive Housing ☐ Retirement Home

☐ Other – Please Specify

☐ Potential Safety Risks for Home or Office Visits – Please Specify

REFERRER INFORMATION

Referrer: ☐ Family Physician ☐ Specialist | Billing Number

☐ Family/Caregiver ☐ Self ☐ Power of Attorney for Personal Care / Substitute Decision Maker (SDM) ☐ Hospital

☐ Agency – Please Specify ☐ Other – Please Specify

Last Name	First Name	
Street Number and Address	City, Prov	Postal Code
Phone	Ext.	Fax

FAMILY PHYSICIAN INFORMATION (IF NOT THE REFERRER)

Last Name	First Name	Phone

<<< Please include relevant/recent consult notes, blood work, etc. >>>

Referrer's Signature:	Date of Referral:

WEST PARK
HEALTHCARE CENTRE

SENIORS MENTAL HEALTH SERVICE
REFERRAL FORM
TELEPHONE: (416) 243-3732
FAX: (416) 243-3735

FOR INTERNAL USE ONLY:		
Date of Referral:		SMHS Chart #:
☐ New Admission	☐ Reassessment	Consultant:
Contact Date:		Appt. Date:

CLIENT/PATIENT NAME: ______________________________

COMMENTS:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____