St. Joseph's Healthcare Hamilton

REFERRAL FORM
Ph: 905-522-1155 Ext 36396
Fax: 905-381- 5613

Seniors Mental Health Clinic & Outreach Services
(Hamilton)

Please note**: We are not a Crisis or an Emergency Service**

Patient Name: _____

Address: _____

City: _____Postal Code: _____

Telephone: _____

Date of Birth: _____Age: _____

HIN: _____Version: _____

Contact Person: _____Relationship:_____

Telephone: _____Bus./Cell:_____ _____

REFERRAL DATE: _____

Living Arrangement:

☐Alone ☐Family ☐Supportive Hsg.
☐LTC Facility ☐Retirement Home

Facility Name:_____

Admit Date to Facility:_____

Family Physician: _____

Ph: _____Fax: _____

Interpreter: ☐ Yes Language: _____

What Is The Reason For Referral *(Eg. Sudden, Ongoing, Degree, etc.?)*

_____

_____

_____

_____

_____

_____

☐ Acute Confusion ☐ Depression ☐ Agitation
☐ Hallucinations ☐ Behaviour changes ☐ Mania
☐ Delusions ☐ Dementia ☐ Anxiety
☐ Substance Abuse/Misuse ☐ Memory changes

Associated Risk Factors

☐ Caregiver Burden/stress ☐ Suicidal Ideation/Attempts
☐ Wandering/Exit Seeking ☐ Aggressive Behaviour
☐ Elder Abuse ☐ Weight loss
☐ Other

FOR PHYSICIANS:

☐ I am referring the above patient to the **COGNITIVE BEHAVIOURAL THERAPY (CBT) GROUP** for depressed older adults.

Medications/Dosages:

Allergies/Drug Intolerances:

Medical/Psychiatric History: (Please forward any consultations)

Is Patient Known to Community Care Access Centre? ☐ Yes ☐ No ☐ Unknown **Case Manager:**

******Please forward most recent bloodwork and any investigations, (e.g. CT scan, EKG) which have been completed. **IF BLOODWORK/URINALYSIS HAVE NOT BEEN COMPLETED WITHIN THE PAST MONTH, WE WOULD RECOMMEND THE FOLLOWING:**

o CBC WITH DIFF (WBC)	o ELECTROLYTES	o LIVER FUNCTION: (AST, ALT, GGT, ALP, BILI)	
o CREATININE/BUN	o TSH	o ALBUMIN	o URINE, R&M AND C&S
o CALCIUM/MAGNESIUM/PHOSPHATE	o B12/ RBC-FOLATE	o GLUCOSE	o ECG

Referral Source: ☐ **Check If Initiated by Family Physician**

Print Name _____ Discipline _____ Phone # _____ FAX # _____

Family MD Signature: _____OHIP Billing #:_____ Date _____

Physician Consultation Letters/Patient Profiles Accepted in Lieu of Referral Form Providing Info On Referral Is Included

******* Missing Information Does Delay The Referral Process *******