St. Joseph's Healthcare Hamilton

BRANT SENIORS MENTAL HEALTH OUTREACH PROGRAM REFERRAL FORM

☐ SJHH – Brant SMHO
☐ BSO Mobile LTCH team

NAME:	UID/CB#
ADDRESS:	DATE OF REFERRAL:
CITY: POSTAL CODE:	REFERRAL SOURCE:
PHONE NUMBER: MARTIAL STATUS:	REFERRAL SOURCE PHONE #:
D.O.B. AGE: H.C.#	FAMILY PHYSICIAN:
CLIENT LIVING WITH: TYPE OF HOUSING: ADM. DATE TO FACILITY:	PHYSICIAN PHONE #: PHYSICIAN FAX #:
CAREGIVER/NEXT OF KIN: RELATIONSHIP: HOME PHONE #: WORK PHONE #:	
CONTACT PERSON RE: APPOINTMENTS, ETC. ☐CLIENT ☐ CAREGIVER/NEXT OF KIN/SDM	CLIENT/SDM consents to REFERRAL: ☐ YES ☐ NO PREFERRED LANGUAGE:

OTHER AGENCIES/SUPPORTS INVOLVED: (List contact & duration of involvement if available)

☐CCAC ☐ CMHA ☐Adult Day Program ☐Alzheimer Society - Support Group, Caregiver Education, BSO Community
☐Meals on Wheels ☐Psychiatrist ☐ Geriatrician ☐Other: (Specify)

REASON FOR REFERRAL / PSYCHIATRIC ISSUE/BEHAVIOUR:	FOR LTCH PHYSICIANS:
	☐ I agree and support my patient living in a LTCH being referred to the Behaviour Support Ontario (BSO) LTCH Mobile Team, as needed.

MEDICATIONS/DOSAGES:

ALLERGIES/DRUG REACTIONS:

MEDICAL / PSYCHIATRIC HISTORY: *(PLEASE FORWARD ANY CONSULTATIONS)*

**PLEASE FORWARD MOST RECENT BLOODWORK AND ANY INVESTIGATIONS (I.E. CT SCAN, EKG, EEG,), 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)	O RBC-FOLATE
O CREATININE/BUN	O TSH	O ALBUMIN	O URINE, R&M AND C&S
O CALCIUM	O B12	O GLUCOSE	O

X

FAMILY PHYSICIAN SIGNATURE: OHIP BILLING NUMBER: DATE:

X

REFERRING PHYSICIAN SIGNATURE: OHIP BILLING NUMBER: DATE:

St. Joseph's Healthcare Hamilton - BRANT SENIORS MENTAL HEALTH OUTREACH PROGRAM
100 West 5th, Hamilton L8N 3K7 Room E116D (Administrative) and
local clinical office at St. Joseph's Lifecare, 99 Wayne Gretzky Parkway, Brantford
Tel: 519-752-3636 Fax: 905-381-5613