

**REFERRAL FORM:**  Seniors Mental Health Outreach Team and/or  BSO Mobile LTCH Team (LTCHs only)

|  |                                       |   |   |
|--|---------------------------------------|---|---|
| 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:                      | PHYSICIAN PHONE #:  |   |
|  | ADM. DATE TO FACILITY:                | PHYSICIAN FAX #:  |   |
| CAREGIVER/NEXT OF KIN:   | RELATIONSHIP:                         | HOME PHONE #:   | WORK PHONE #:   |
| CONTACT PERSON RE: APPOINTMENTS, ETC.<br><input type="checkbox"/> CLIENT <input type="checkbox"/> CAREGIVER/NEXT OF KIN/SDM  |                                       | CLIENT/SDM consents to REFERRAL: <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| OTHER AGENCIES/SUPPORTS INVOLVED: (List contact & duration of involvement if available)  |                                       | PREFERRED LANGUAGE:   |   |
| <input type="checkbox"/> CCAC <input type="checkbox"/> Community Nursing <input type="checkbox"/> Adult Day Program <input type="checkbox"/> Alz. Soc. Support Group <input type="checkbox"/> Veteran's Affairs<br><input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Home Help <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Geriatrician <input type="checkbox"/> Other: (Specify) |                                       |   |   |
| REASON FOR REFERRAL / PSYCHIATRIC ISSUE/BEHAVIOUR:   |                                       |   | <b>FOR PHYSICIANS:</b><br><input type="checkbox"/> I agree and support my patient living in a LTCH being referred to the Behavioural 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:   |                                       |   |   |
| <input type="checkbox"/> CBC WITH DIFF (WBC)   | <input type="checkbox"/> ELECTROLYTES | <input type="checkbox"/> LIVER FUNCTION: (AST, ALT, GGT, ALP)                             | <input type="checkbox"/> RBC-FOLATE   |
| <input type="checkbox"/> CREATININE/BUN  | <input type="checkbox"/> TSH          | <input type="checkbox"/> ALBUMIN  | <input type="checkbox"/> URINE, R&M AND C&S   |
| <input type="checkbox"/> CALCIUM   | <input type="checkbox"/> B12          | <input type="checkbox"/> GLUCOSE  | <input type="checkbox"/>  |

X  
 FAMILY PHYSICIAN SIGNATURE: \_\_\_\_\_ OHIP BILLING NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

X  
 REFERRING PHYSICIAN SIGNATURE: \_\_\_\_\_ OHIP BILLING NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

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