Sinai Health | 恆康中心 Seniors' Wellness Centre
A Community Mental Health Program for Seniors and Caregivers

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Scarborough, ON. M1V 0B8
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REFERRAL FORM FOR COMMUNITY AGENCIES

Name of Agency:	**Name of Worker:**
Address: **Email Address:**	**Tel. no.** **Fax no.**

Client's Information

Name:	**Gender: M / F**
Health Card no.:	**Language (Dialect):** ☐ Cantonese ☐ Mandarin ☐ English ☐ other dialect:
Date of Birth (YY/MM/DD): **Patient MUST be 65 years old or above**	**Marital Status:** ☐ Single ☐ Married/Common Law ☐ Divorced ☐ Separated ☐ Widowed
Address:	
Telephone no(s): **Primary** ☐ H / ☐ C : **Other** ☐ H / ☐ C :	**Contact Person for appointment:** ☐ Patient ☐ Family Member **Name:** **Relationship:** **Tel. no.:**
Email:	

Service(s) Requested:

☐ Supportive Counselling ☐ Psychotherapy ☐ Caregiver intervention	* For Psychiatric Assessment, Medication Consultation and Diagnostic Clarification, please encourage patient's primary physician to send us a completed FP Referral Form

Brief Description of Present Mental Health Difficulties or Other Psycho-social Problems

Brief Medical/Psychiatric History (if applicable, incl. hospitalization, medications, surgeries, etc.)

Immediate Risks or Concerns (e.g. aggression, self-harm, addiction)

Signature of Referring Worker:_____ **Date:**_____