Sinai Health

Department of Psychiatry

Please read before completing/submitting the referral form

GERIATRIC PSYCHIATRY OUTPATIENT CLINIC REFERRAL
Instructions and Information

Please review the following information with your patient:

The Department of Psychiatry makes decisions regarding care based on balancing needs, availability of resources, and patient preference. Care may include psychiatric consultation, psychosocial assessment, and time limited treatment interventions. Please note: Not all patients will be seen by a psychiatrist, and emphasis will be on providing episodes of care.

Inclusion criteria: Age 65+ (except for cognitive assessments) and able to attend outpatient care.

To ensure access to all patients, we are not able to provide assessments for patients who have been assessed or treated by a geriatric psychiatrist in Ontario in the past year. These patients should be directed to care with the practitioner who has been involved in their care. If a second opinion or a transfer of care is being requested, we kindly ask the treating psychiatrist to be involved in making the referral. Similarly, if the referring physician belongs to a hospital system with geriatric psychiatry services, we kindly ask that the referrals be directed within their hospital system.

The Clinic does not offer psychiatric assessments for legal, insurance, custody, CAS, WSIB or forensic reasons.

This form is not for individuals experiencing crisis.
Patients experiencing a mental health or addiction emergency
should be directed to the nearest emergency department.

Referral Process: Please ensure the patient is aware of this referral. Within two weeks, the referring physician will receive a letter acknowledging the referral along with resources. A telephone intake with the patient may be scheduled to gather more information and determine next step. Patients will be contacted regarding an appointment. Intake staff will make **two** attempts to reach the patient and leave two voice mail messages. The number will appear as Sinai Health. If we are unable to reach the patient, the referral source will be notified by fax and the referral form will be inactivated.

Patients are welcome to contact us directly at 416-586-8888 ext. 5192 to discuss their referral at any time.

How to submit a referral:

- Review the above information with the patient to ensure expectations are aligned
- Fax the completed form to 416-586-3231
    - ***Please Note:*** *All fields must be completed. If a field is not applicable, please enter ‘n/a’. Incomplete forms will be returned to the referral source*
- Fax each referral form individually
- To help us provide the best care, please include all relevant documents including previous psychiatric/ geriatric/ neurologic consultations or discharge summaries, psychological reports, medication sheets, medical reports, lab and test results

GERIATRIC PSYCHIATRY OUTPATIENT CLINIC REFERRAL

FAX TO: 416-586-3231 INQUIRIES: 416-586-4800 ext. 5192

60 Murray Street – Suite L1-012, Toronto ON M5T 3L9

CLEAR FORM

Patient Information:

* Last Name: ______________________ * First Name: ______________________

* Preferred Name: ______________ * Health Card#:__________________ * Version Code: _____

* Pronouns: ____________ * Birthdate: ________________Age:____________

* Address: ____

* City: ______________ * Province: _______ * Postal Code: ______________

Considerations: ☐ N / A

☐ Cognitive Impairment ☐Hearing Impairment ☐Sight Impairment ☐ Mobility Challenges

☐ Language Barrier (specify language needed for translation) ____________

☐ other: ____

☐ Case manager ____

☐ Ontario Health at Home Care Coordinator ______________________________

Who should we call with an appointment: ☐ Patient ☐ Alternate contact

Contact Information: *By listing phone numbers/email addresses below, the referral source confirms that the client consents for Sinai Health to call/email them or their alternate contact regarding this referral and appointment booking.*

* Phone: ______________________________ **Consent to leave message:** ☐yes ☐no

Email : ______________________________

Alternate contact: Relationship: ______________

Name: ______________________________ Phone #: ______________________

Referral Source Information:

* Name: ______________________ * ☐ MD ☐ NP * Billing #: ______________

* Address: ____

* Signature: ______________________ * Phone #:

* Referral Date: ______________________ * FAX # :

* Primary Care Provider Name: ______________ * Phone #:

*** Has patient been assessed by a psychiatrist in the past?** ☐ yes ☐ no *(If yes please attach consultation)*

If yes, when was the most recent assessment: ______________________________

Please attach consultation note if available

*** Has patient been assessed by a psychiatrist at Sinai Health in the past?** ☐ yes ☐ no

*** Reason for Referral:**

Primary psychiatric complaint/clinical question:

PHQ9 and GAD 7 score recommended for ALL Mood and Anxiety referrals *(forms available at www.phqscreeners.com/select-screener):*

Please check all that apply

- ☐ Diagnostic Clarification
- ☐ Treatment Recommendations
- ☐ MD to MD Telephone Consult

Risk & Safety – Please include ALL past and current behaviours ☐ N/A

☐ Violence ☐ Agitation ☐ Self Harm ☐ Suicide attempt ☐ Suicidality ☐ Serious Physical Impairment

☐ Other **DETAILS:**

Current & Past History – Please check all that apply and attach relevant notes/consults ☐ Attached reports

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Trauma Symptoms/PTS ☐ Substance Use Concerns

☐ Psychosis ☐ Cognitive Decline/Confusion ☐ ADHD/Learning Disability ☐ Obsessive Compulsive Disorder

☐ Other ______________________________

DETAILS:

*** Mental Health & Addictions Treatment – Past and Present** (*therapies, hospitalizations & community agency involvement*) ☐ N/A ☐ See attached reports

DETAILS:

*** Medical History:** *Please attach relevant clinical and medical documentation* ☐ See attached reports

DETAILS:

Is the patient followed by a medical specialist at Sinai Health? ☐No ☐Yes

If yes, MD name ______________

Medication History (*Please list all current medications (psychiatric and non psychiatric) and past psychiatric medications (if available) –or attach list if necessary* ☐ See attached list

DETAILS:

Medication Name	Current	Dose	Frequency	Response & Adverse Effects
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			