Sinai Health | 恆康中心 Seniors' Wellness Centre

A Community Mental Health Program
for Seniors and Caregivers

Please read before completing/submitting the referral form

SENIORS' WELLNESS CENTRE REFERRAL
Instructions and Information

Please review the following information with your patient:

About the Seniors' Wellness Centre

Our Seniors' Wellness Centre is designed to meet the **mental health** needs of older adults (**65 years old and above**) who may benefit from culturally sensitive and linguistically appropriate mental health services in Chinese.

Our inter-professional team provides mental health services to these older adults, and their families/care partners - such as assessments, treatments, education, health promotion, and wellness programs.

Our services are provided in Cantonese, Mandarin and English in the following areas:

- Assessments and treatment recommendations by psychiatrists and/or mental health clinicians
- Time-limited treatment interventions, such as:
  - Medication management
  - Psychotherapy and supportive counselling for patients, and their families/care partners
- Psychoeducation and resources
- Health promotion
- Wellness programs
- Coordinated care, which may include referrals to other or related community programs

Please note: Not all patients will be seen by a psychiatrist. Also, the service scope is on providing episodic care.

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

Exclusion Criteria

- **Under 65 years old (except for Care partners)**
- **Long-term care residents**
- **Referral involving active legal issues (including but not limited to MVAs and WSIB)**
  - Criminal/Legal Issues
  - Individuals requiring third-party assessments (e.g. lawyer/court, child welfare services, insurance purposes, WSIB, MVA)
- **Individuals who are bedbound/housebound**
- **Individuals already receiving palliative care services**
- **Primary referral reasons:**
  - Cognitive issues **without** behavioral or psychological symptoms (BPSD)
  - Traumatic brain injury
  - Developmental disorder, such as ADHD, Autism Spectrum Disorder (ASD), or Developmental Delay
  - Genetic/chromosomal syndrome
  - Capacity assessment
  - Case management (e.g. housing support; applications of community support services; benefits application, etc. Patients may contact local seniors' social service organizations or call 211.)
  - Primary substance use disorders - Patient can self-refer to Metro Addiction Assessment Referral service (MAARS) at 416-599-1448 and Addiction Services York Region (ASYR) at 905-841-7007 or 1-800-263-2288. If patients are interested in seeing an addiction doctor, they can self-refer to their closest Rapid Access Addictions Medicine (RAAM) clinic – https://www.metaphi.ca/raam-clinics

Referral Process: Please ensure the patient is aware of this referral. An eligible patient will be scheduled for a telephone screening by a mental health clinician to gather more information and determine next steps. The clinician will make **three** attempts to reach the patient and leave voice messages if available. Within a month, the referring physician will receive a letter acknowledging the disposition status. 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 416-291-3883 to discuss their referral at any time.

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REFERRAL FORM FOR PHYSICIAN OR NURSE PRACTITIONER

3660 Midland Ave. Unit 103, Scarborough, ON, M1V 0B8 **Tel**: (416) 291-3883 Please **Fax** the completed form to: **(416) 291-8813**

PLEASE CONFIRM by checking ☑ the applicable boxes :

☐ This referral does **NOT** involve active litigation (including but not limited to MVAs and WSIB)

☐ Patient/Substitute Decision Maker (SDM) is informed of the referral to our clinic and provided **voluntary consent** for the specialist service.

This is a Referral for :

☐ Psychogeriatric services for patients **(≥ 65 years old)** who may benefit from culturally appropriate services in Chinese

☐ Caregiver/Care Partner Intervention

EXCLUSION Criteria

- **Under 65 years old (except for Caregivers/ Care partners)**
- **Long-term care residents**
- **Active legal involvements, e.g.**
  - Criminal/Legal issues
  - Requiring 3rd party assessments (e.g. lawyer/court, child welfare services, insurance purpose, WSIB, MVA)
- **Primary referral reasons :**
  - Cognitive issues **without** behavioral or psychological symptoms (BPSD)
  - Traumatic brain injury
  - Developmental disorder
  - Genetic/chromosomal syndrome
  - Bedbound/Housebound
  - Already receiving Palliative Care services
  - Capacity assessment
  - Primary substance use disorders (Patient can self-refer to Metro Addiction Assessment Referral service (MAARS), Addiction Services York Region (ASYR) + RAAM Clinic

*** This service is NOT for individual experiencing crisis. Patients experiencing a mental health or addiction emergency should be directed to the nearest emergency department.**

Name of Referring Physician:	**Physician's Billing No. :**
Address:	**Tel. No.**
Email :	**Fax No.**

INFORMATION OF : ☐ the **Patient** (**MUST be 65 ≥**) ☐ the **Caregiver / Care Partner**

Name:	**Gender:** ☐ M ☐ F ☐ Other
Health Card No.:	**Languages (Dialects):** ☐ Cantonese ☐ Mandarin ☐ English ☐ Other dialect:
Date of Birth (YY/MM/DD):	**Marital Status:** ☐ Single ☐ Married/Common Law ☐ Divorced ☐ Separated ☐ Widowed ☐ Other
Address:	**Contact Person for appointment:** ☐ Patient ☐ Family Member/SDM **Name:** **Relationship:** **Tel. no.:** Can a message be left? ☐ Yes ☐ No
Telephone No(s): **Primary** ☐ H / ☐ C : **Other** ☐ H / ☐ C : Can a message be left? ☐ Yes ☐ No	
Email:	

Reason(s) for Referral (please check all that apply):

☐ Psychiatric Assessment for patient
☐ Medication Consultation for patient
☐ Diagnostic Clarification for patient
☐ Psychotherapeutic service for patient
☐ Psychotherapeutic service for caregiver
☐ MD-to-MD Consultation

Brief Description of Current Mental Health Difficulties or Other Psycho-social Problems: (please check all that apply)

☐ Mood issues
☐ Anxiety issues
☐ Stress/Adjustment issues
☐ Sleep difficulties
☐ Bereavement
☐ Behavioural & Psychological Symptoms of Dementia (BPSD)
☐ Psychosis
☐ Others: _____

Brief Description of Current Condition:

Risks Profile / Factors

☐ Current Substance misuse / ☐ History of Substance misuse
☐ Current Self Harm / ☐ History of Self Harm
☐ Suicidal ideation ☐ Suicide attempt
☐ Current Aggression / ☐ History of Aggression
☐ Family history of mental health concerns
☐ Risk of fall

Brief Description of Current Condition:

Brief Psychiatric History (if applicable, incl. hospitalization, medications, previous psychiatrists, etc.)

□ Has this patient had previous psychiatric admissions to a hospital? □ Yes □ No, most recent admission: _____
□ Has this patient been referred to another facility or physician for psychiatric consultation in last 12 months? □ Yes □ No
If yes, provide names: _____

Please provide a brief description of the patient's psychiatric history:

Brief Medical History (incl. medical conditions, surgeries, hospitalization, etc.)

□ Metabolic Syndrome/Diabetes
□ Sensory Deficits (e.g., hearing or visual impairment)
□ Parkinsonism
□ Sleep apnea _____
□ Stroke/Heart disease _____
□ Currently followed by a geriatrician _____
□ Currently followed by a neurologist _____
□ Currently followed by GAIN or RGP or Other _____

Please provide brief description:

Current Medications (Please list ALL medications with dosages) and/or Treatments

Allergies:

Attachments Checklist: (the following documents MUST be attached to the referral)

□ **Most recent Lab results** (preferably within 1 year)
- □ **Hematology:** CBC
- □ **General Chemistry:** e.g., Electrolytes, Liver enzymes, BUN, A1C, Creatinine, eGFR, UREA, Calcium, Albumin, TSH, Vit. B12
- □ **Microbiology:** Urine Culture & Sensitivity
- □ **Urinalysis**
- □ **Therapeutic blood level monitoring** if applicable**:** Epival, clozapine, lithium
- □ **Neuroimaging report** if available (e.g. CT, MRI)
- □ **ECG** if available

□ **Previous Psychiatric records (including any ER and inpatient reports) if available**
□ **Geriatric Medicine Consultation report if available**
□ **Neurologist Consultation report if available**
□ **Sleep study/Sleep medicine consultation report if available**
□ **Current Medication Administration Record (MAR) (if applicable)**
□ **Summary of progress notes**

Thank you for your referral

- Incomplete or ineligible referrals will be returned to you for completion.
- Please send relevant reports **ONLY**.
- Our clinician will make **three** attempts to reach the patient or contact person for a **telephone screening** and leave voice messages if available. Within a month, the referring physician will receive a letter acknowledging the disposition status.
- **Please note:** if we require further information, we will contact the referrer for clarification before confirming our involvement in the care of the patient.

Signature of Referring Physician/Nurse Practitioner: _____ Date: _____