Sinai Health | 恆康中心 Wellness Centre

A Community Mental Health Program
for Seniors and Caregivers

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**

This is a Referral for :

☐ **Psychogeriatric services for patients (65 years old and above) who may benefit from culturally appropriate services in Chinese**	☐ **Caregiver/Care Partner Intervention**

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

EXCLUSION Criteria

- **Under 65 years old (except for Caregivers/ Care partners)**
- **Long-term care residents**
- **Primary referral reason:**
  - Traumatic brain injury
  - Developmental disorder
  - Genetic/chromosomal syndrome
  - Bedbound/Housebound and not able to use virtual method of contact
  - Already receiving Palliative Care services
  - Capacity assessment
  - Criminal/Legal Issues
  - Primary substance use disorders (Patient can self-refer to Metro Addiction Assessment Referral service (MAARS), Addiction Services York Region (ASYR) + RAAM Clinic
  - require 3rd party assessments (e.g. lawyer/court, child welfare services, insurance purpose, WSIB)

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

INFORMATION OF : ☐ Patient **MUST be 65 ≥** ☐ **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:	
Telephone No(s): **Primary** ☐ H / ☐ C : **Other** ☐ H / ☐ C : Can a message be left? ☐ Yes ☐ No	**Contact Person for appointment:** ☐ Patient ☐ Family Member/SDM **Name:** **Relationship:** **Tel. no.:** Can a message be left? ☐ Yes ☐ No
Email:	

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

☐ Psychiatric Assessment for patient	☐ Psychotherapeutic service for patient
☐ Medication Consultation for patient	☐ Psychotherapeutic service for caregiver
☐ Diagnostic Clarification for patient	☐ 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 Consultation report if available**
□ **Neurologist 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 contact the patient and or the contact person within **14 days** for a telephone screening.
- **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: _____