North Bay Regional Health Centre
Seniors' Mental Health – Regional Consultation Service
120 King St. W
North Bay, ON P1B 5Z7
Telephone: 705-494-3054 Fax: 705-494-3097

Referral Form

Incomplete referrals may delay intake process

PATIENT INFORMATION			
Last Name	First Name		Sex ❑ M ❑ F
Date of Birth (dd/mm/yyyy)	Health Card #		Version Code
Address (Street/Unit #)	City	Postal Code	Phone #
Preferred Language	Length of time at current residence	Lives Alone ❑No ❑Yes If No specify:	
Next of Kin (Last Name, First Name)	Relationship		Phone #
Contact Person: ❑ Patient ❑ Next of Kin ❑ Other Name: Relationship:			Phone #

REFERRAL SOURCE			
Family Physician	Phone #	Fax#	Does the patient consent to this referral? ❑ No ❑Yes

Request for Referral Initiated By:
❑ Family Physician ❑ Patient ❑ Nurse Practitioner ❑ Other (specify):

AGENCY INVOLVEMENT

❑ LHIN Home & Community Care ❑ Mental Health Services ❑ Alzheimer Society
❑ North East Specialized Geriatric Centre ❑ Other (Specify)

REASON FOR REFERRAL

❑ Cognitive changes
(Please provide copies of cognitive screening if available)
❑ Mood symptoms
❑ Psychotic symptoms
❑ Functional changes
❑ Behavioural changes
❑ Other

LIST ANY RISKS TO PATIENT OR OTHERS

BRIEF DESCRIPTION OF PRESENTING CONCERN / GOAL FOR REFERRAL

May we refer this patient to Behavioural Supports Ontario (BSO) if appropriate? ☐No ☐Yes

Are there any legal/third party issues? ☐No ☐Yes
Please specify:

Office Use Only: Date rec'd._____ Initial _____ NB#_____
Previous SMH-RCS file: ❑ No ❑ Yes Previous/Current BSO file: ❑ No ❑ Yes

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Name: _____

PSYCHIATRIC HISTORY
Please Include Reports of Recent Hospitalizations and Relevant Consultations
(e.g. psychiatry, neurology, cognitive screening).

MEDICAL/SURGICAL HISTORY
Please Include Reports of Recent Hospitalizations and Relevant Consultations

LABORATORY INVESTIGATIONS (Please attach results)

- ❑ CBC
- ❑ Serum Creatinine, eGFR
- ❑ Serum Electrolytes (including calcium, magnesium, and phosphorus)
- ❑ TSH
- ❑ B12
- ❑ Serum Drug Levels, if applicable
  (e.g., lithium or other mood stabilizers, anticonvulsants, digoxin)

Done at Time of Referral or Within Past 3 Months

RADIOLOGY REPORTS (Please attach results)

- ❑ ECG (Done at time of referral or within past 3 months)
- ❑ CT / MRI scan results (if applicable/available)

CURRENT MEDICATIONS (Please include dose & frequency.)

❑ Medication list attached Name of Pharmacy: _____

ALLERGIES

ADDITIONAL COMMENTS

Date	Signature of Referring Physician/Nurse Practitioner

We will contact you if we require further information or if unable to register the patient with our service.

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Consent to collect personal and personal health information:
BY PROVIDING US WITH YOUR PERSONAL AND PERSONAL HEALTH INFORMATION WE WILL ASSUME THAT YOU HAVE CONSENTED TO OUR COLLECTION, USE AND DISCLOSURE OF THAT PERSONAL AND PERSONAL HEALTH INFORMATION FOR THE PURPOSE SPECIFIED, OR THE PURPOSE DESCRIBED IN THIS
POLICY, AT THE TIME OF COLLECTION.

NOTE: If you are not the individual or the individual's authorized substitute decision maker (SDM) you must obtain the express consent of the individual to share the information with us and to submit this referral.
Where the individual is not capable of consenting to the collection, use or disclosure of his or her own personal information, please ensure consent is obtained from the person who is legally entitled to consent on behalf of that individual.

What we do with the information we collect:
The personal and personal health information collected on the Referral Form is used to determine your/the individual's eligibility for Seniors' Mental Health services. We will also use this information to contact you/the individual to arrange any required appointments for assessment. The information is kept confidential and stored in a secure electronic database, and becomes part of your/the individual's electronic health record.

You have the right to:
Withdraw consent for some of the above uses and disclosures by contacting us;
Access and / or request corrections to personal health information you have legal rights to.
For more information about our privacy practices, to discuss withdrawing consent, or to raise privacy concerns or complaints, please contact:

Privacy Office
North Bay Regional Health Centre
50 College Drive
North Bay ON P1B 0A4
705-474-8600, extension 3320
fippa@nbrhc.on.ca

If you are not satisfied with our response to your privacy concerns, you can call or make a formal complaint to the Information and Privacy Commissioner of Ontario at:

Information and Privacy Commissioner of Ontario
2 Bloor Street East, Suite 1400
Toronto, Ontario M4W 1A8
Tel: 1-800-387-0073
www.ipc.on.ca (https://www.ipc.on.ca)

Is the information I submit secure and confidential?
By submitting the referral form, you are accepting the terms of this agreement and willingly sending us your/the individual's information to initiate a referral to Seniors' Mental Health. We employ technical security measures to protect the privacy of the data being submitted.