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| **Required Referral Form to Access NBRHC’s Nipissing Specialized Geriatric Services** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If you have a preferred service, please check the appropriate box (*optional*): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Seniors’ Mental Health** | | | | | | | | | | | | | | | | | | | | |  | **Geriatric Medicine Clinic** | | | | | | | | | | | | | | | | | | |  | | **Behavioural Supports Ontario** | | | | |
| *All information will be considered during the intake process and referrals will be triaged to the most appropriate service(s).* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Demographics** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name *(last, first*): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | DOB (*dd/mm/yyyy*): | | | | | | | | | | |  | | | | | |
| Gender: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Health Card #: | | | | | | | | | |  | | | | | | | | | | Version Code: |  |
| Preferred Language: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address (*unit/street #)*: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: | | | |  | | | | | | | | | | | | | | | | | Postal Code: | | | | | | |  | | | | | | | | | | | Phone #: | | | | | |  | | | |
| Lives alone:  No  Yes | | | | | | | | | | | | | | | | | | | | If no, please specify: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Secondary Contact: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone #: | | | | | |  | | | |
| Did patient/SDM consent to this referral?  No  Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Comments: | | | | | | |  | | | | | | | |
| **Person to Contact Regarding this Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Patient | | | | | | | | |  | | Secondary Contact | | | | | | | | | | | | | Other (*if other, please specify below)* | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | |  | | | | | | | | | | | | | | | | | | | Relationship: | | | | | | | |  | | | | | | | | Phone #: | | | | | |  | | |
| **Agency Involvement** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Home & Community Care | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Mental Health Services | | | | | | | | | | | | | |
|  | | | Alzheimer Society | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | North East Specialized Geriatric Centre | | | | | | | | | | | | | |
|  | | | Other (*please specify*): | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Cognitive changes | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Mobility/falls | | | | | | | | | | | | |
|  | | Behavioural changes | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Functional changes | | | | | | | | | | | | |
|  | | Mood symptoms | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Incontinence | | | | | | | | | | | | |
|  | | Symptoms of psychosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Pain management | | | | | | | | | | | | |
|  | | Suicidal/homicidal ideation | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Sleep disturbance | | | | | | | | | | | | |
|  | | Substance/Medication misuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Unintended changes in weight/nutrition | | | | | | | | | | | | |
|  | | Polypharmacy/Medication Review | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Complex medical problems | | | | | | | | | | | | |
|  | | Caregiver/family concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Multiple ED visits secondary to geriatric  syndromes | | | | | | | | | | | | |
|  | | Social isolation | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Other (*please specify*): | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Brief Description and Clinical Question** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Legal Concerns** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are there any legal concerns (consent, capacity, abuse, etc.)?  No  Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please specify: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has a MTO report been completed?  No  Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Risks and/or Safety Concerns (*for patient and others*)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relevant Medical, Surgical & Psychiatric History –** *Please attach any relevant clinical information from your EMR (e.g. notes from recent visits, consult notes) that would not already be available in Connecting Ontario.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Please attach Medication list/CPP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Allergies** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Required Investigations for Seniors’ Mental Health and Geriatric Medicine Clinic Referrals**  *Please ensure the following recent (within the last 3 months) results are available:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | CBC | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | TSH, B12 | | | | | | | | | | | | | |
|  | | | HbA1c | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | ECG | | | | | | | | | | | | | |
|  | | | Creatinine, eGFR | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | VDRL (if risk factors) | | | | | | | | | | | | | |
|  | | | Electrolytes and calcium, albumin, magnesium, and phosphorus | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Serum Drug Levels (e.g. lithium or other mood stabilizers, anticonvulsants, digoxin) if applicable | | | | | | | | | | | | | |
|  | | | CT/MRI scan results (required for referrals related to cognitive changes) | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Completed cognitive screening assessments if available (e.g. MMSE/MoCA) | | | | | | | | | | | | | |
| **Additional Comments** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Care Provider:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print Name: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone #: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Fax # (*if applicable*): | | | | | | | | | | | | |  | | | | | |
| **Request for Referral Initiated by (*please specify):*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Patient | | | | | | | | | | | | | | | | | | |
| Primary Care Provider | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Other: | | | | | | | |  | | | | | | | | | | |
| **Referring Physician/Nurse Practitioner (*if different than PCP*):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print Name: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone #: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | Fax # (*if applicable*): | | | | | | | | | | | | |  | | | | | |
| **Date (*dd/mm/yyyy*):** | | | | | | | | | | | | | |  | | | | | | | | | | | **Signature:** | | | | | | | |  | | | | | | | | | | | | | | | |

**Please fax the completed form to 705-494-3097. We will contact you if we require further information or if unable to register the patient with our services.**