

Seniors' Mental Health Community Consultation Service

NORTH SHORE COMMUNITY SUPPORT SERVICES, INC.

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Referral Form

Date of Referral: _____

Referring Physician: _____

Referring Nurse Practitioner _____

Patient Name: _____

DOB: _____

Health Card Number: _____

Phone #: _____

Address: _____

Phone #: _____

Contact Person: _____

Phone #: _____

Relationship to Client: _____

Reason For Referral:

Development of Problem:

Is this a new behaviour/problem?

Yes No

Duration:

Days Wks Mths Yrs

Is there a danger to the client or someone else?

Yes No

Degree of caregiver stress:

Mild Mod. Severe

Past Psychiatric History:

Past Medical History:

Medications:

Allergies:

Suggested Investigations Prior to Referral (please attach results and relevant consultations):

1. Full medical evaluation, including physical examination
2. CBC, electrolytes, Ca, Mg, PO4, BUN, Cr, glucose, urinalysis
3. Liver enzymes, bilirubin, total protein, albumin
4. TSH, serum B12, RBC folate, VDRL, HIV (if risk factors)
5. Serum drug levels, if applicable (e.g. digoxin, lithium, tricyclic antidepressants, anticonvulsants)

Date: _____

Signature: _____

NB: The Seniors' Mental Health program cannot provide emergency service. Emergency situations should be referred to the Emergency Department of the nearest general hospital.