

Seniors Mental Health Integrated Referral (Edmonton Zone)

Complete all sections of this form, and return by fax to only **one** of the following programs.

Program

- Covenant Health Community Geriatric Psychiatry - Hys Centre
- Covenant Health Geriatric Psychiatry (*Villa Caritas*)
- Glenrose Specialized Geriatric Psychiatry (*all services*)
- Continuing Care Psychiatric Consulting Service (*CCPCS*)

Fax

780.424.4964
780.342.6579
780.735.8821
780.735.3344

Phone

780.342.9100
780.342.6552
780.735.8820
780.735.3300

Client Information <i>(print clearly)</i>			
Last Name		First Name	
Date of Birth <i>(yyyy-Mon-dd)</i>	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Personal Health Number	
Address	City	Province	Postal Code
Home Phone		Alternate Phone	
Geriatric Psychiatry Service Requested			
<input type="checkbox"/> In-home assessment/treatment		<input type="checkbox"/> Inpatient assessment / treatment	
<input type="checkbox"/> Outpatient clinic assessment/treatment		<input type="checkbox"/> Follow up post discharge	
<input type="checkbox"/> Day Program (<i>Covenant Health, Hys Center, Ermineskin</i>)		<input type="checkbox"/> Telepsychiatry consultation	
<input type="checkbox"/> Community Consultation		<input type="checkbox"/> Unsure	
<input type="checkbox"/> Day Hospital (<i>Glenrose S.T.A.R.T. Psychiatry</i>)			
Reason for referral/current concerns			
Date of Referral <i>(yyyy-Mon-dd)</i>			
Living Situation			
<input type="checkbox"/> Home		<input type="checkbox"/> Lodge	
<input type="checkbox"/> Supportive living (DAL)		<input type="checkbox"/> Assisted living	
<input type="checkbox"/> Other, specify _____		<input type="checkbox"/> Care facility	
Lives with			
<input type="checkbox"/> Spouse		<input type="checkbox"/> Other family	
<input type="checkbox"/> Alone		<input type="checkbox"/> Other <i>(specify)</i> _____	
Current location		Name of contact person	
Phone		Relationship	
Referring Source			
Name of Referring Source		Program Area	
Phone		Fax	
Name of Family Physician		Physician Number	
Physician Phone		Physician Fax	
Does the family physician agree with the referral?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			

Affix patient label within this box.

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Does the client/guardian/agent agree with referral? Yes
 No

Providers/Services Currently Involved

Home Living Supportive Living Day Program

Name of Case Manager	Phone
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Name of Client Coordinator	Phone
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Name of Contact	Phone
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Mental Health (*specify and contact information*)

Previous Geriatric/Psychiatric Assessment (*attach summary*)

Medical History

At risk for hospitalization due to acute medical condition? Yes
 No

Pending Medical Consults (*notes & dates*)

Psychiatric History

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Psychosocial <i>(check all that apply)</i>					
Mood					
<input type="checkbox"/> Depressed		<input type="checkbox"/> Anxious		<input type="checkbox"/> Angry	
<input type="checkbox"/> Suicidal thoughts		<input type="checkbox"/> Thoughts of harming others		<input type="checkbox"/> Euphoric	
<input type="checkbox"/> Other <i>(specify)</i> _____					
Screen	Score	Date <i>(yyyy-Mon-dd)</i>	Screen	Score	Date <i>(yyyy-Mon-dd)</i>
GDS			Cornell		
Behaviour					
<input type="checkbox"/> Agitation		<input type="checkbox"/> Aggression-physical		<input type="checkbox"/> Aggression-verbal	
<input type="checkbox"/> Impulsive		<input type="checkbox"/> Wandering		<input type="checkbox"/> Disinhibited	
<input type="checkbox"/> Withdrawn		<input type="checkbox"/> Rummaging		<input type="checkbox"/> Hoarding	
<input type="checkbox"/> Vocalizing		<input type="checkbox"/> Sun downing		<input type="checkbox"/> Insomnia	
<input type="checkbox"/> Resisting care					
Thought Disturbance					
<input type="checkbox"/> Hallucinations		<input type="checkbox"/> Paranoia		<input type="checkbox"/> Delusional	
Substance Use					
<input type="checkbox"/> Tobacco		<input type="checkbox"/> ETOH		<input type="checkbox"/> Other <i>(specify)</i> _____	
Has the patient been to a Treatment Program					
<input type="checkbox"/> Yes, complete				▶ Date <i>(yyyy-Mon-dd)</i>	
<input type="checkbox"/> No				▶ Site	
Cognitive Status					
Is patient impaired?			<input type="checkbox"/> Judgment impaired		
<input type="checkbox"/> Yes, complete			<input type="checkbox"/> Insight impaired		
<input type="checkbox"/> No			<input type="checkbox"/> Executive dysfunction		
Screen	Score	Date <i>(yyyy-Mon-dd)</i>	Screen	Score	Date <i>(yyyy-Mon-dd)</i>
SMMSE			EXIT		
MoCA			FAB		
RUDAS					
Communication impaired?					
<input type="checkbox"/> Normal		<input type="checkbox"/> Expressive		<input type="checkbox"/> Receptive	
<input type="checkbox"/> Other <i>(specify)</i> _____					
Associated Changes					
<input type="checkbox"/> No Change					
<input type="checkbox"/> Sleep / rest pattern					
<input type="checkbox"/> Appetite					
<input type="checkbox"/> Weight					
<input type="checkbox"/> Energy level					
<input type="checkbox"/> Interests / activities					
<input type="checkbox"/> Functional ability <i>(specify)</i> _____					

Attach

- Copies of relevant consultations
- Medication profile *(length of time on medication)*
- PT / OT / SW / Nursing and Physician Progress Notes and/or summary notes of prior 3 to 7 days
- Behaviour-mood observation tracking / summary

NOTE: Please *DO NOT* send information that is available on NetCare