**Central Intake**

**Mental Health Services for the Elderly Date:**

**Referral is for (choose one):** [ ]  **Mental Health Services for the Elderly Team**

[ ]  **Direct Geriatric Psychiatry Consultation** (one-time community outpatient consultation only;

referral must be by primary healthcare provider) 

Please complete BOTH PAGES of the form and FAX to Central Intake at (204) 785-4870 or 1-866-757-6206.

Or on EMR, Task the referral to the “Mental Health Intake” role.

**Section 1:**

|  |  |  |
| --- | --- | --- |
| LEGAL NAME (Last)       | LEGAL NAME (First)       | OTHER NAMES (aka)       |
| PHONE #       | DOB (dd/mmm/yy)        | PHIN #       | GENDER [ ]  Male[ ] Female | MARITAL STATUS [ ]  M [ ]  S [ ]  D [ ]  W SPOUSE:       |
| MHSC #       |
| PHYSICAL ADDRESS (physical address, room/apt #, 911 identifier including mailing address)        | CITY       | POSTAL CODE       |
| Is the person aware of referral? [ ]  Yes [ ]  No Is family aware of referral? [ ]  Yes [ ]  No  | Is the person in agreement? [ ]  Yes [ ]  No Is family in agreement? [ ]  Yes [ ]  No  |

**Section 2:**

|  |  |
| --- | --- |
| REFERRAL SOURCE: (Name & Professional Role)       | PHONE #       FAX #       |
| REASON FOR REFERRAL & SAFETY CONCERNS: (please describe, in detail, the presenting problem, symptoms, & concerns)         WHAT ARE YOU REQUIRING (what is the question that needs to be answered)?       |

**Section 3:**

|  |  |  |
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| PRIMARY CONTACT/NEXT OF KIN:       | RELATIONSHIP TO PERSON BEING REFERRED:       | PHONE #       |
| NAME OF PRIMARY HEALTHCARE PROVIDER:       |
| POWER OF ATTORNEY? [ ] Yes [ ]  No  | RELATIONSHIP TO PERSON BEING REFERRED:       | PHONE #       |
| IS HOME CARE INVOLVED? [ ]  Yes [ ]  No  | HOME CARE CASE COORDINATOR’S NAME:       |

**Section 4:**

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|  **TO BE SIGNED BY THE INDIVIDUAL’S PRIMARY HEALTHCARE PROVIDER PRIOR TO REFERRAL BEING SENT** There is a consulting geriatric psychiatrist attached to our team and this resource may be engaged to consult on  this referral, when this is indicated or requested. Please indicate your agreement with this consultation, should it  be indicated, by signing below:            Primary Healthcare Provider’s Name Primary Healthcare Provider’s Signature |

**Section 5:**

|  |  |
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| MEDICAL DIAGNOSIS:       |  |
| HISTORY OF MENTAL HEALTH CONCERNS? [ ]  Yes [ ]  No SPECIFY:      Is the person experiencing suicidal ideation? [ ]  Yes [ ]  No  | HISTORY OF COGNITIVE IMPAIRMENT? [ ]  Yes [ ]  No SPECIFY:       |

**Section 6:**

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| Please ensure the following have been addressed:  [ ] Pain [ ]  Constipation [ ]  Infection [ ]  Hydration [ ]  Recent Medication Changes (all types)  Other:       |
| List all recent medication changes made within the ***last 3 weeks*** including additions, deletions, and dosage changes:       |
| Please specify any recent behavioural changes and indicate how long behavior has been present:       |

**Section 7:**

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| Please detail any other pertinent information or changes:       |

**Section 8:**

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| **Please attach the following to facilitate referral. If not applicable, please indicate.**  |
| [ ]  | **N/A** [ ]  | EKG |
| [ ]  | [ ]  | A list of current medication |
| [ ]  | [ ]  | A copy of the Behaviour Mapping/DOS  |
| [ ]  | [ ]  | Copy of recent MMSE and/or MOCA  |
| [ ]  | [ ]  | Copy of recent Discharge Summaries i.e. Crisis Stabilization Unit, SMHC, hospital |
| [ ]  | [ ]  | Copy of recent neurology or other applicable specialty reports |

**Please ensure that you have completed both pages of the referral fully before sending or it will be returned.**