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Geriatric Psychiatry Day Hospital Program Referral Form

PATIENT INFORMATION ***(Please print legibly)***

Name (Last, First): _____ **Sex:** ☐ **Male** ☐ **Female**

Marital Status: ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Single**

Date of Birth: ___ _/__ __/___ _ **(65 or older)** **Language:** ☐ **ENG** ☐ **FRE** ☐ **Other** _____
DD/MM/YY ***(Please specify)***

Patients Address:

City: **Postal Code:** **Health Card #:** _____ **Version Code:** _____

Telephone: Home: ( )
Telephone: Work: ( )

Can patient self toilet ? **YES** **NO**
Is patient a wander risk ? **YES** **NO**
Is patient a fall risk ? **YES** **NO**
Other safety concerns (seizure, colostomy, choking)? _____

ParaTranspo number if available:

Patient is willing to participate in group programming? YES NO

Next of Kin/POA: **Relationship:** _____

Name:_____ POA: ☐ Yes ☐ No
IS POA CONSENT ING TO DH ADMISSION ☐ YES ☐ NO

Telephone: Home ( )
Work ( )
Cell ( )

Who shall we contact with the appointment time?

□ Patient
□ Family – Relationship:_____
□ Other – Relationship: _____

Name :

Telephone:

Referring Geriatrics Psychiatrist:

Address:

Telephone: Work ( )
Fax ( )

Outpatient Geriatric Psychiatrist:

Address:
Telephone :
Fax:

Family Physician:

Name: _____

Address:

Telephone: Work ( )
Fax ( )

Clinical Information

Reason(s) for Referral:

Goals for Admission/Discharge:

Priority: □ Elective (patient is safe where they are and will be offered an admission when one is available)
□ Urgent (Needs placement immediately within 1-3 weeks)

*****MANDATORY*** M.O.C.A score in the last 6 months:_____*****

List of All current Medications (please attach list of medications)

Name and Telephone number of dispensing Pharmacy:

N.B. THIS INFO IS VERY IMPORTANT FOR A PROPER ASSESSMENT

Background info attached: relevant background info i.e. blood work, CT scans, X-ray reports, medications tried, admission/discharge info from chronic care hospital, consults by geriatric medicine, neurology, psychiatry or other related specialties

Referral to Other day Hospital Program □ Yes □ No

*Please Note: Once discharged the patient will be returned to you for follow up. Initial for acceptance of patient care up d/c: _____

**Note: referral can only be made by geriatric psychiatrist, if not yet seen by geriatric psychiatrist, refer to Ottawa Geriatric Psychiatry services referral

Referring Physician Signature: _____ **Date:** _____

FAX TO:
Fax: (613) 798-2999