THE ROYAL

Geriatric Psychiatry Outreach Program Referral Form

LTCH: _____ Room #: _____ Date of Adm to LTC: ___/___/___
DD MM YY

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

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

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

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

Health Card # _____ **Version Code** _____

POWER OF ATTORNEY / SUBSTITUTE DECISION MAKER:

Relationship:

Name:

Address: **Postal Code:**

Telephone: **Home:** **Cell:**
Work:

REFERRAL INFORMATION

Referring Physician:

Last Name:_____ **First Name (not initial):**_____

THE FOLLOWING INFORMATION IS ESSENTIAL

REASON FOR REFERRAL:

PERTINENT MEDICAL HISTORY:

Previous psychiatric assessment: ☐ No ☐ Yes *By Whom?* _____ *(*Please obtain Reports if *Yes)*

Referring Physician's Signature: _____ **Date:** _____

REFERRAL DECLINED BY ROMHC (Please add to chart in LTCH)

REASON:

Signature:_____ **Date:** _____

****NB:** Verbal or signed *ROMHC Consent to Disclose Personal Health Information* form **MUST** accompany referral form.

FAX TO: 613-798-2999 ☐ ROMHC - 1145 Carling Ave., Ottawa ON K1Z 7K4 ☐ Tel: 613-722-6521, ext. 6001