



# Referral Form to The Royal's Behavioural Support/ Geriatric Psychiatry Outreach Services

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## PATIENT INFORMATION

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Language:  English  French  Other: \_\_\_\_\_  
DD/MM/YYYY

Phone (if available): \_\_\_\_\_

Preferred pronouns (check all that apply):

 She/her  He/him  They/them  Other: \_\_\_\_\_  Prefer not to disclose

Gender identity (check all that apply):

 Woman  Man  Trans woman  Trans man  Non-binary  Two-spirit Other: \_\_\_\_\_  Prefer not to disclose

Health card number: \_\_\_\_\_ Version: \_\_\_\_\_

### Substitute decision maker (SDM)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Is the patient or their SDM aware that they have been referred to The Royal?  Yes  NoIs there an active finding of incapacity?  Yes  No  Unknown

## CURRENT LOCATION OF PATIENT

Please indicate where patient is being referred from and provide a date of admission, and phone and fax numbers, as applicable. You must select one of the following:

 Home  Retirement home  Long-term care (LTC) home  Acute careDate of admission: \_\_\_\_\_  
DD/MM/YYYY

Location name and/or address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## REFERRAL INFORMATION

### Primary care provider

Full name: \_\_\_\_\_ Signature: \_\_\_\_\_

 Doctor  Nurse practitionerDate: \_\_\_\_\_  
DD/MM/YYYY

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



# Referral Form to The Royal's Behavioural Support/ Geriatric Psychiatry Outreach Services

## REFERRAL INFORMATION CONTINUED

**Referral source** (only complete if different from above primary care provider):

Full name: \_\_\_\_\_ Signature: \_\_\_\_\_

Role: \_\_\_\_\_ Date: \_\_\_\_\_  
DD/MM/YYYY

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Previous psychiatric assessment:  Yes  No If yes, by whom: \_\_\_\_\_

Are Behavioral Support Ontario (BSO) services currently involved?  Yes  No  N/A

### Reason for referral

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Please provide any relevant information available, including:

- Delirium workup  Diagnostic imaging/urine/bloodwork  Current medications/recent changes
- Relevant consults  BSO documents (i.e. BSO-DOS®, BSA)  Other: \_\_\_\_\_

### Additional information

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### PLEASE FAX COMPLETED FORM TO:

If Ottawa, Cornwall or Stormont, Dundas and Glengarry – Fax: 613-715-5824 | Telephone: 613-722-6521 ext. 6001  
If Brockville, Lanark, Leeds and Grenville – Fax: 613-498-1495 | Telephone: 613-345-1461 ext. 1700