

REFERRAL FORM

CLIENT INFORMATION

Client Name: _____ Date of Birth (D/M/Y): _____
 Address: _____ City: _____ Postal Code: _____
 Home Phone: _____ Alternate Phone: _____
 Health Card #: _____ Interpreter required: No Yes Language: _____
 Able to attend at clinic: Yes No Any transportation barriers? Yes (specify below) No
 Lives Alone: Yes No (With Whom): _____ Driving Status: _____
 Pharmacy: _____ Phone: _____ Fax: _____

CONTACT PERSON INFORMATION

Contact Name: _____ Relationship to Client: _____
 Home Phone: _____ Alternate Phone: _____
 Who should be contacted for appointment? Client Next of Kin/POA/SDM All
 Alert – Do **NOT** call: _____ SDM Name, if applicable: _____

PRIMARY HEALTH CARE PROVIDER

MD/NP Name: _____
 Address: _____ Phone: _____ Fax: _____

REASON FOR REFERRAL (Check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Multiple Complex Medical Problems | <input type="checkbox"/> Altered Coping/Isolation | <input type="checkbox"/> Safety Concerns |
| <input type="checkbox"/> At Risk/Has Experienced Falls | <input type="checkbox"/> Impaired Mobility | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Caregiver Stress/Situation | <input type="checkbox"/> Functional Decline | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Mental Health/Addictions | <input type="checkbox"/> Cognitive Decline | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Psychosocial Problems | <input type="checkbox"/> Medication Assessment | |
| <input type="checkbox"/> Other (specify): _____ | | |

RESPONSIVE BEHAVIOURS (Check all that apply):

- Wanders (Explores) (aimless wandering, exit seeking, pacing, wandering in wheelchair):** Wanders aimlessly in and out of rooms; wanders and will leave immediate environment if not prevented; wanders halls but does not attempt to leave immediate environment; and exit seeks.
- Hoarding/Collecting/Rummaging:** Hoards food or medication; collects objects which are lying around, but does not search others' belongings; and rummages others' belongings looking for food, medications or objects.

- Agitated Behaviour:** State of restlessness, inability to relax, pacing; nagging, pleading, calling out; and repetitiveness, unrealistic fears.
- Verbally Aggressive/Angry Behaviour (using obscenity, profanity, different from normal behaviour):** Displays anger or is verbally abusive in predictable situation, i.e., when provoked; and angry or verbally aggressive with no apparent provocation.
- Physically Aggressive/Angry Behaviour (spitting, kicking, grabbing, pushing, throwing objects, hitting self/others):** Displays anger, physically aggressive in predictable situations, i.e., when provoked; and angry or physically aggressive with no apparent provocation.
- Indiscriminate Ingestion of Foreign Substances:** Ingests, eats foreign substances; and ingests foreign substances/objects, requires frequent supervision.
- Suspicious Behaviour (fear of abandonment or harm, stealing belongings and hiding objects, infidelity, etc.):** Occasionally suspicious of food or people; hallucinations - please describe; suspicious of most people/food but behaviour does not disrupt daily routine; and suspicious of most people/food to extent it interferes with daily routines, i.e., eating.
- Sexual Behaviour (sexually suggestive remarks, grabbing, touching, exposing self in public, etc.):** Exposes self or makes unwelcome sexual remarks or gestures; and touches others in an unwanted sexual manner.
- Resists Treatment or Refuses Care:** Resists or refuses but can be persuaded to comply; and resists or refuses and misses treatment as a result (e.g., refuses medications or therapies).
- Low/Depressed Mood and/or Suicidal Behaviour:** Exhibits behaviour but participates in activities (no change in normal routine); exhibits behavior and refuses to participate/no interest (change from normal routine); verbalizes ideas of suicide, history of prior threats or attempts; verbalizes plan for suicide; and previous attempted suicide (indicate if and where resident was hospitalized).
- Other:** Inappropriate elimination of stool/urine different from normal; substance misuse/abuse - illicit drugs, alcohol; unsafe smoker - smokes and puts out butts in non-designated areas; burns self/other, clothing and environment; hides cigarettes and lighter/matches, etc.; and undressing self in public.
- _____

HEALTH INFORMATION/CONSENT (Please attach copies of the following as applicable):

- Medication List/Allergies/Drug Interactions Diagnostic Reports (Labs, CT Scan, MRI, ECG, X-rays)
- Consultation notes Client Agreed to Referral? Yes No
- Links/referrals to community agencies including geriatric services: _____
- Additional Comments: _____

REFERRAL SOURCE

- MD/NP Community Self-Referral Family Other: _____
- Name: _____ Address: _____
- Telephone: _____ Fax: _____