Alberta Health Services

Affix patient label within this box.

Seniors Mental Health Integrated Referral
(Edmonton Zone)

Complete all sections of this form, and return by fax to only **one** of the following programs.

Program	Fax	Phone
☐ Edmonton Mental Health Clinic Geriatric Psychiatry Services *(108 St)*	780.342.7621	780.342.7700
☐ Covenant Health Community Geriatric Psychiatry - Hys Centre	780.424.4964	780.424.4660
☐ Covenant Health Geriatric Psychiatry *(Villa Caritas)*	780.342.6579	780.342.6552
☐ Glenrose Specialized Geriatric Psychiatry *(all services)*	780.735.8821	780.735.8820
☐ Continuing Care Psychiatric Consulting Service *(CCPCS)*	780.735.3344	780.735.3300

Client Information *(print clearly)*

Last Name		First Name	
Date of Birth *(yyyy-Mon-dd)*	Gender ☐ M ☐ F	Personal Health Number	
Address		City	Province / Postal Code
Home Phone		Alternate Phone	

Geriatric Psychiatry Service Requested

- ☐ In-home assessment/treatment
- ☐ Outpatient clinic assessment/treatment
- ☐ Day Program *(Covenant Health, Hys Center, Ermineskin)*
- ☐ Community Consultation
- ☐ Day Hospital *(Glenrose S.T.A.R.T. Psychiatry)*
- ☐ Inpatient assessment / treatment
- ☐ Follow up post discharge
- ☐ Telepsychiatry consultation
- ☐ Unsure

Reason for referral/current concerns

Date of Referral *(yyyy-Mon-dd)*

Living Situation

☐ Home ☐ Lodge ☐ Assisted living ☐ Care facility
☐ Supportive living (DAL) ☐ Other, specify ______________________

Lives with

☐ Spouse ☐ Other family ☐ Alone ☐ Other*(specify)*______________

Current location	Name of contact person
Phone	Relationship

Referring Source

Name of Referring Source	Program Area
Phone	Fax
Name of Family Physician	Physician Number
Physician Phone	Physician Fax

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Does the family physician agree with the referral? ☐ Yes ☐ No	
Does the client/guardian/agent agree with referral? ☐ Yes ☐ No	
Providers/Services Currently Involved ☐ Home Living ☐ Supportive Living ☐ Day Program	
Name of Case Manager	Phone
Name of Client Coordinator	Phone
Name of Contact	Phone
☐ Mental Health (*specify and contact information)*	
☐ Previous Geriatric/Psychiatric Assessment *(attach summary)*	
Medical History	
At risk for hospitalization due to acute medical condition? ☐ Yes ☐ No	
☐ Pending Medical Consults *(notes & dates)*	
Psychiatric History	

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Psychosocial *(check all that apply)*

Mood

☐ Depressed ☐ Anxious ☐ Angry ☐ Euphoric
☐ Suicidal thoughts ☐ Thoughts of harming others ☐ Other *(specify)*____________________

Screen	Score	Date *(yyyy-Mon-dd)*	Screen	Score	Date *(yyyy-Mon-dd)*
GDS			Cornell		

Behaviour

☐ Agitation ☐ Aggression-physical ☐ Aggression-verbal
☐ Impulsive ☐ Wandering ☐ Disinhibited
☐ Withdrawn ☐ Rummaging ☐ Hoarding
☐ Vocalizing ☐ Sun downing ☐ Insomnia
☐ Resisting care

Thought Disturbance

☐ Hallucinations ☐ Paranoia ☐ Delusional

Substance Use

☐ Tobacco ☐ ETOH ☐ Other *(specify)*____________________

Has the patient been to a Treatment Program ☐ Yes, complete ▶ ☐ No

Date *(yyyy-Mon-dd)*

Site

Cognitive Status

Is patient impaired? ☐ Yes, complete ▶ ☐ No

☐ Judgment impaired
☐ Insight impaired
☐ Executive dysfunction

Screen	Score	Date *(yyyy-Mon-dd)*	Screen	Score	Date *(yyyy-Mon-dd)*
SMMSE			EXIT		
MoCA			FAB		
RUDAS					

Communication impaired?

☐ Normal ☐ Expressive ☐ Receptive ☐ Other*(specify)*____________________

Associated Changes

☐ No Change
☐ Sleep / rest pattern
☐ Appetite
☐ Weight
☐ Energy level
☐ Interests / activities
☐ Functional ability *(specify)*____________________

Attach

☐ Copies of relevant consultations
☐ Medication profile *(length of time on medication)*
☐ PT / OT / SW / Nursing and Physician Progress Notes and/or summary notes of prior 3 to 7 days
☐ Behaviour-mood observation tracking / summary

NOTE: Please *DO NOT* send information that is available on NetCare