Alberta Health Services

Seniors Mental Health Program Referral

Client First Name	Client Last Name	Date of Birth *(dd-Mon-yyyy)*	Gender ☐ Female ☐ Male
Personal Healthcare Number	Address		Postal Code
Referral Date *(dd-Mon-yyyy)*	Referred by		

Client Location ☐ Home ☐ Acute Care Hosp ☐ Seniors Lodge ☐ Continuing Care ☐ Other *(specify)* _____	Phone Number	Fax Number
Name of Physician / Is Physician aware of this referral? ☐ Yes ☐ No	Phone Number	Fax Number

Reason for Referral *(presenting problems)*

Please send a current medication profile with this referral.

Expected Outcomes

- ☐ Assessment by Seniors Outreach Nurse
- ☐ Behaviour Management Strategies
- ☐ Nursing Interventions
- ☐ Consideration for Admission to CCMHBI
- ☐ Medication Review
- ☐ Other *(specify)*

The following lab work results are **REQUIRED** prior to assessment and **current within one month**

Albumin	Lipid profile
ALP	Folate
ALT	Vitamin B 12
AST	TSH
Bilirubin	CBC
Calcium	Urinalysis
Creatinine	Chest X-ray
Electrolytes	CT Scan *Head (if possible)*
Glucose-fasting	ECG
Magnesium	Urea

Is the client / guardian aware of this referral and has verbal consent been given ☐ Yes ☐ No

Name of Next of Kin	Phone Number	Alternate Number
Trustee/Power Of Attorney Existing? ☐ No ☐ Yes ☐ Activated	Name	Phone Number
Personal Guardian/Directive: ☐ No ☐ Yes ☐ Activated	Name	Phone Number