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
☐ Covenant Health Community Geriatric Psychiatry - Hys Centre	780.424.4964	780.342.9100
☐ 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

Does the family physician agree with the referral? ☐ Yes ☐ No

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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