Seniors' Mental Health Community Consultation Service
NORTH SHORE COMMUNITY SUPPORT SERVICES, INC.
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Referral Form

Date of Referral:_____
Referring Source:_____ Phone #:_____
Patient Name:_____ Address:_____
DOB:_____ Phone #:_____
Health Card Number:_____

Contact Person:_____ Relationship to Client:_____
Phone #:_____

Reason For Referral:

Development of Problem:

Is this a new behaviour/problem?	□ Yes □ No
Duration:	□ Days □ Wks □ Mths □ Yrs
Is there a danger to the client or someone else?	□ Yes □ No
Degree of caregiver stress:	□ Mild □ Mod. □ Severe

Past Psychiatric History:

Past Medical History:

Medications:

Allergies:

Suggested Investigations Prior to Referral (please attach results and relevant consultations):

1. Full medical evaluation, including physical examination
2. CBC, electrolytes, Ca, Mg, PO4, BUN, Cr, glucose, urinalysis
3. Liver enzymes, bilirubin, total protein, albumin
4. TSH, serum B12, RBC folate, VDRL, HIV (if risk factors)
5. Serum drug levels, if applicable (e.g. digoxin, lithium, tricyclic antidepressants, anticonvulsants)

Date:_____ Signature:_____

NB: The Seniors' Mental Health program cannot provide emergency service. Emergency situations should be referred to the Emergency Department of the nearest general hospital.