Providence Care

PERSONAL HEALTH INFORMATION

HOSPITAL MENTAL HEALTH INPATIENT REFERRAL

Fax referral to Providence Care Central Intake 613-548-5595
Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral

REFERRAL: ☐ ADULT MENTAL HEALTH (AMH) ☐ SENIORS MENTAL HEALTH (SMH)

Please note: we are not a crisis or emergency service
If you feel that your patient is too ill to tolerate the wait for an assessment/admission, please consider accessing a psychiatric crisis service or emergency room at the nearest hospital serving your patient's community.

CLIENT/PATIENT DEMOGRAPHICS

Name: _____
Address: _____
Telephone: _____
Permission to Leave Voicemail ☐ Yes ☐ No
Date of Birth (YYYY/MM/DD): _____
Health Card#: _____

Gender: ☐ Male ☐ Female ☐ Other: _____
Marital Status: ☐ Unknown
☐ Married ☐ Common-law ☐ Separated
☐ Divorced ☐ Widowed ☐ Single/Never married

FRENCH LANGUAGE SERVICES

Client/patient speaks/understands English: ☐ Yes ☐ No Interpreter Required ☐ Yes ☐ No
Other languages spoken: _____

ALTERNATE CONTACT

Name: _____
☐ Power of Attorney (POA)/Substitute Decision Maker (SDM): _____
☐ Spouse: _____
☐ Other: _____
Telephone: _____
Permission to Leave Voicemail ☐ Yes ☐ No

REASON FOR REFERRAL/FACTORS CONTRIBUTING TO CURRENT REFERRAL

(please include environmental stressors):

☐ Inability to care for self due to mental illnesss
☐ Medication review and stabilization
☐ Behavioural and psychological symptoms associated with dementia
☐ Poor functioning in community
☐ Substance misuse
☐ Threat or danger to self
☐ Self harm/Suicide
☐ Threat or danger to others
☐ Symptoms of mood
☐ Symptoms of anxiety
☐ Symptoms of psychosis
☐ Signs of cognitive impairment

Other: _____

PSYCHIATRIC DIAGNOS(E)S:

MEDICAL DIAGNOS(E)S (IF KNOWN OR SUSPECTED):

ALLERGIES:

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RISKS

- ☐ Medication non-adherence
- ☐ Gambling
- ☐ Physical/verbal aggression
- ☐ Agitation
- ☐ Arson/fire setting
- ☐ Drug misuse
  - ☐ Street drugs
  - ☐ Prescription
- ☐ Other: _____
- ☐ Alcohol misuse
- ☐ Choking/aspiration/dysphagia
- ☐ Sexual aggression
- ☐ Weapons
- ☐ Wandering/elopement
- ☐ Eating disorders
- ☐ Tobacco/Nicotine use
- ☐ Living alone
- ☐ Sexual disinhibition
- ☐ Falls: If yes, describe functional mobility/assistive devices: _____

LEGAL STATUS/MENTAL HEALTH ACT

☐ Voluntary ☐ Involuntary ☐ Form#:_____ Expiry Date: YYYY/MM/DD ☐ Contesting involuntary form

☐ Community Treatment Order Expiry Date: YYYY/MM/DD Pending Charges: ☐ Yes ☐ No

CAPACITY TO CONSENT

Capable to Consent to Treatment: ☐ Yes ☐ No ☐ Unknown

If no, please identify Substitute Decision Maker (SDM)/
Power of Attorney (POA)/ Public Guardian & Trustee (PG&T): Name: _____Phone Number: _____

Capable to Manage Property: ☐ Yes ☐ No ☐ Unknown

If no, please identify Substitute Decision Maker (SDM)/
Power of Attorney (POA)/ Public Guardian & Trustee (PG&T): Name: _____Phone Number: _____

Form 33 Completed: ☐ Yes ☐ No Date: YYYY/MM/DD

FUNCTIONAL ABILITIES

Personal Hygiene:	☐ Independent	☐ Needs prompts	☐ Needs assistance
Special Senses:	☐ Visual impairment	☐ Hearing impairment	☐ Wheelchair/walker
Ambulation:	☐ Walks without assistance	☐ Walks with assistance	☐ Unsteady
Eating:	☐ Independent	☐ Needs prompts	☐ Needs assistance
Sleep:	☐ Normal	☐ Insomnia	☐ Daytime sleeper
Communication:	☐ Receptive dysphasia	☐ Expressive dysphasia	

Income Sources (please specify): ☐ ODSP ☐ OAS ☐ CPP ☐ VAC ☐ Other: _____

COLLATERAL INFORMATION (please attach)

- ☐ Admission/discharge summaries
- ☐ Diagnostic imaging
- ☐ Consultations
- ☐ Lab values
- ☐ Psychological assessments
- ☐ Functional assessments
- ☐ Psychosocial assessment
- ☐ Nursing notes
- ☐ Cognitive testing (MMSE/MOCA)
- ☐ ER notes/assessments
- ☐ Psychiatric Assessments
- ☐ Medication list/Medication Administration Record (MAR)

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CURRENT LOCATION AT TIME OF REFERRAL

- ☐ Private House/Apt.
- ☐ Retirement Home/Senior's Residence
- ☐ Long Term Care Facility/Nursing Home
- ☐ Acute Mental Health Care – Inpatient
- ☐ Setting for persons with intellectual disabilities
- ☐ Mental health residence (eg. psychiatric group home)
- ☐ Other: _____

REFERRING PHYSICIAN/PSYCHIATRIST/NURSE PRACTITIONER

Name: _____

Phone: _____

Primary Health Care Provider (if different from above)

Name: _____

Phone: _____

Community Agency/Resources Involved (past or present):

THIS SECTION MUST BE COMPLETED BY THE REFERRING PSYCHIATRIST

Referral Completed By (please print): _____

Signature: _____

Agency Name: _____

Phone: _____ Fax: _____

DATE OF REFERRAL: YYYY/MM/DD

Client/SDM aware of referral: ☐ Yes ☐ No

Client/SDM agrees to referral: ☐ Yes ☐ No

OFFICE USE ONLY

Date Referral Received: YYYY/MM/DD Date Declined: YYYY/MM/DD Date Accepted: YYYY/MM/DD MRN#: _____

Date Referral Pre Registered: YYYY/MM/DD Date Admitted: YYYY/MM/DD

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HOSPITAL MENTAL HEALTH
INPATIENT REFERRAL

ADULT MENTAL HEALTH

Admission Criteria: 16 years of age or older, medically stable with a primary diagnosis of severe mental illness as defined by DSM V Axis 1 such as Schizophrenia, Schizoaffective Disorder, Mood Disorders such as Bipolar I or II or a Major Depressive Disorder, that requires complex aftercare, relapse prevention and/or specialized treatment or diagnostic procedures. Clients with a primary diagnosis of Developmental Delay, Substance Abuse, Personality Disorder, Psychosexual Disorder, Neurological Illness, Adjustment/Conduct Disorder, Eating Disorder or Brain Injury may be considered if there is strong suggestion of a comorbid Axis 1 diagnosis, but only for the purposes of assessment and stabilization. A letter that commits to accept the client back to the referring facility is a condition of acceptance of these individuals.

Outpatients serviced by Providence Care, Mental Health Services or other specialized community mental health services, whose treatment history is well-known to Providence Care who are relapsing, may be admitted directly with approval of the program.

Admission for social and/or financial reasons would not be considered appropriate.

Type of Service: Provides specialty mental health services to clients with serious and persistent mental illness who cannot be managed within the existing array of first line and intensive services.

SENIORS MENTAL HEALTH

Admission Criteria: Older patients, usually over 65 with dementia, experiencing severe and frequent responsive behaviors or age-related psychological symptoms that cannot be managed in their current setting. Medical co-morbidities must be stable and consent from patient or substitute decision maker is required unless patient is being admitted under the Mental Health Act.

Type of Service: Provides inter-professional assessment, diagnosis, rehabilitation and stabilization to older patients with behavioral disturbances related to dementia that require high intensity support.