Providence Care

PERSONAL HEALTH INFORMATION

BEHAVIOURAL SUPPORT SERVICES REFERRAL
SENIORS MENTAL HEALTH OUTREACH

☐ Kingston P: 613-384-9088 Fax: 613-384-6107 ☐ Frontenac Lennox & Addington P: 613-354-3916 Fax: 613-354-6673
☐ Hastings Prince Edward P: 613-771-0133 Fax: 613-771-0916

Mandatory Eligibility Criteria – Select one of the following:

☐ Older adult with late-onset Major Mental Health disorder (initial onset >65 yrs. e.g. major depression , bipolar disorder, anxiety disorders, schizophrenia and psychotic disorders, and substance use disorders)
☐ Older adult with confirmed or suspected progressive Dementia
☐ Younger adult (under 65 yrs.) with suspected progressive Dementia such as Alzheimer's Disease, Vascular Dementia, Fronto-Temporal Dementia

Seniors Mental Health does not typically provide service to individuals with longstanding mental illness who have reached age 65 and who are receiving services through other adult or community mental health services. Referrals requesting clarification of cognitive impairment or age related mental health issues that could benefit from the expertise of geriatric psychiatry will be considered on a case-by-case basis by contacting your local Central Access team about options for consultation.

Seniors Mental Health Outreach does not typically provide long term follow up; we focus on assessment and linking people to community support.

Priority

Our services typically maintain a wait-list for initial assessments, individuals in need of emergency services should be referred to local acute care mental health services.
https://providencecare.ca/community-services/crisis-support/

If you feel this referral is urgent, please call your local Seniors Mental Health Outreach Team office and ask to speak with the Central Access clinician.

PERSON BEING REFERRED:

Last Name	Given Name	Health Card	Code
Address	**City/Province**	**Postal Code**	
Telephone#	**Date of Birth**	**Marital Status**	**Gender**

Preferred Language: ☐ English ☐ French ☐ Other:

Interpreter Required: ☐ Yes ☐ No

Current location (if not at home):

CONTACT PERSON: (Preferences indicated here imply consent)

Last Name	Given Name	Phone Number	☐ SDM ☐ POA ☐ NOK

Who should we contact first? _____

DIGITAL COMMUNICATION PREFERENCES: (Preferences indicated here imply consent)

Preferred Cell Phone _____ ☐ Client ☐ Contact Person

Preferred Email _____ ☐ Client ☐ Contact Person

Incomplete referrals will result in a delay of service, we cannot proceed until all information is received

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REASON FOR REFERRAL
Why are you referring now? (Diagnosis, community support services, treatment review, symptom management, frequent ER/health care provider visits)
What have you already tried? (Previous interventions, community supports/resources, medication)

RISK ASSESSMENT			
Alcohol/Substance Misuse	☐ Yes ☐ No	Suicidal Ideation	☐ Yes ☐ No
Agitation	☐ Yes ☐ No	Responsive Behaviours- - Verbal	☐ Yes ☐ No
Caregiver Stress	☐ Yes ☐ No	- Physical	☐ Yes ☐ No
Driving	☐ Yes ☐ No	- Sexual	☐ Yes ☐ No
Fire	☐ Yes ☐ No	Wandering	☐ Yes ☐ No
Suspiciousness	☐ Yes ☐ No	Weapons	☐ Yes ☐ No

SUPPORTING DOCUMENTATION		
Mandatory Documentation		
☐ CBC	☐ TSH	☐ Electrolytes
☐ Fasting Glucose or HbA1C	☐ B12	☐ Calcium
☐ Patient Profile	☐ Medication List	☐ Medical History

Please Attach if Available/Applicable		
☐ Delirium workup	☐ Head imaging	☐ LFTs
☐ Internal cognitive assessment(s) and notes	☐ Psychiatry consultations	☐ Coordinated Care Plan
☐ Nurse Navigator Reports	☐ Current ECG	☐ Other relevant consults

REFERRAL SOURCE		
Name/Agency	Telephone	Fax
Date of Referral: YYYY/MM/DD Time: HH:MM Print Name: _____ Signature: _____		
Most Responsible Physician		
Print Name: _____ Signature: _____		☐ Has consented to referral