MEDICAL PSYCHIATRY ALLIANCE

Trillium Health Partners

REFERRAL FORM
CENTRE FOR SENIORS' MEDICAL PSYCHIATRY

150 Sherway Drive, 4th Floor, Toronto ON, M9C 1A5
Tel: 416-521-4057 • Fax: 416-521-4177

Client Name (Surname, Given Name): _____

☐ M ☐ F DOB *(DD/MM/YYY)*: _____ Age: ____

Health Card #: _____ / _____ / _____ Version Code: ____

Address: _____

_____

Phone #: ( ) - _____ Alternate #: ( ) - _____

Referral Date (DD/MM/YYYY): _____ **Reg/UID#:** _____ **(Internal Use Only)**

CLIENT INFORMATION:

Lives With: ☐ Alone ☐ Spouse/Partner ☐ Family ☐ Other: _____

Preferred Language: ☐ English ☐ Other: _____ Interpreter Required? ☐ Yes ☐ No _____

Has the client consented to the referral? ☐ Yes ☐ No

ALTERNATE CONTACT INFORMATION: Person to contact to schedule appointment

☐ Client ☐ Caregiver / Next of Kin: _____ Relationship: _____

Telephone #: ( ) - _____ Alternate #: ( ) - _____

REFERRAL CRITERIA: Clients ≥ 65 years of age residing in the Mississauga Halton LHIN with:

Any chronic medical condition impacting function AND depressed mood or anxiety

Please indicate the reason for referral? _____

Primary medical condition impacting function: _____

Mental health/mood concern: _____

Please complete PHQ-2 with patient: Over the past 2 weeks, how often have you been bothered by any of the following problems	**Not at all**	**Several Days**	**More than half of the days**	**Nearly every day**
Low interest of pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Please attach any relevant health information:

☐ Medical /Psychiatric History ☐ Recent Hospital Discharge Summary

☐ Recent Investigations (e.g. diagnostics, labs) ☐ Current Medications – Please attach list

REFERRAL SOURCE INFORMATION: ☐ Family Physician ☐ Nurse Practitioner ☐ Other: _____

Name: _____ **Signature:** _____ **OHIP Billing Number:** _____

Preferred method of communication: Please select

Phone: ( ) - _____ Fax: ( ) - _____ Email*: _____

*Only THP or One Mail accepted as a mode of secure email communication

EXCLUSION CRITERIA:

1. Moderate to severe dementia (refer to either Seniors' Services or Seniors Mental Health Services)
2. Behavioural and Psychological Symptoms of Dementia (BPSD) such as agitation, aggression (refer to Seniors Mental Health Services)
3. Positive psychotic symptoms (refer to Seniors Mental Health Services)
4. Active suicidal ideation or attempt within last year (refer to Seniors Mental Health Services)
5. Psychiatric admission within last year (refer to Seniors Mental Health Services)
6. Falls and / or Continence as primary issues (refer to Seniors' Service)