Affix patient label within this box

Covenant Health

Seniors Mental Health Referral

Complete all sections of this form and return by fax to only one of the following programs. Visit www.albertareferraldirectory.ca to review admission eligibility criteria.

Program	Fax	Phone
☐ Covenant Health Community Geriatric Psychiatry *(Lakewood Community Health Centre)*	780.424.4964	780.342.9100
☐ Covenant Health Acute Inpatient Geriatric Psychiatry *(Villa Caritas)*	780.342.6579	780.342.6509

Client Information *(print clearly)*			
Last Name	First Name		
Date of Birth *(yyyy-Mon-dd)*	Personal Health Care Number		
Address	City	Province	Postal Code
Home phone	Alternate phone		

Geriatric Psychiatry Service Requested

☐ In-home assessment/treatment
☐ Outpatient clinic assessment/treatment
☐ Recreation Therapy
☐ Inpatient assessment/treatment
☐ Follow up post-discharge
☐ Unsure

Reason for referral/current concerns

Date of referral *(yyyy-Mon-dd)*

Living Situation

☐ Home
☐ Supportive Living (PSL)
☐ Supportive Living (DSL)
☐ Long Term Care
☐ Memory Care/ Secure Unit
☐ Group Home
☐ Lodge
☐ Other, specify_____

Lives with

☐ Spouse
☐ Other, family
☐ Alone
☐ Other, specify_____

Current location	Name of contact person
Phone	Relationship

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Referring Source	
Name of referring source	Program area
Phone	Fax
Name of family physician	Physician number
Physician phone	Physician fax
Has the family physician been contacted and agree with the referral? ☐ Yes ☐ No	
Does the client/guardian/agent agree with the referral? ☐ Yes ☐ No Name of person agreeing to referral (client/guardian/agent)	
Providers/Services currently involved ☐ Home Care ☐ Supportive living ☐ Day Program ☐Other Specify:	
Name of Case Manager	Phone
Name of Site Contact	Phone
☐ Mental Health Supports *(specify name and contact information)*	
☐ Previous Geriatric/Psychiatric Assessment *(attach summary)*	

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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

☐ Suicide thoughts ☐ Thoughts of harming others ☐ Other *(specify)*_____

Screen	Score	Date *(yyyy-Mon-dd)*	Screen	Score	Date *(yyyy-Mon-dd)*
GDS			Cornell		
GAD-7			C-SSRS		

Behavior

☐ Agitation ☐ Aggressive – physical ☐ Hoarding

☐ Impulsive ☐ Aggressive – verbal ☐ Insomnia

☐ Withdrawn ☐ Wandering ☐ Sun downing

☐ Vocalizing ☐ Rummaging

☐ Resisting care ☐ Disinhibited

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 the patient impaired?

☐ Yes, complete →

☐ No

☐ Judgement impaired

☐ Insight impaired

☐ Executive dysfunction

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			Provide details on cognitive impairment:		
Screen	**Score**	**Date** *(yyyy-Mon-dd)*	**Screen**	**Score**	**Date** *(yyyy-Mon-dd)*
MoCA			SLUMS		
RUDAS			MMSE		

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

☐ Behavior-mood observation tracking/summary

NOTE: Please DO NOT send information that is available on NetCare or Connect Care