

## WENDAT SERVICES FOR SENIORS

## Psychogeriatric Services Program Referral Form – <u>TRANSITION SERVICE</u>

Referred by: Organization name and address:			Date of Referral: Referral Contact: Name: Phone #: Fax #				
<b>Client Information</b>	ı <u>:</u>						
Client name:				DOB:		HC#	
				Marital			
Address:				Status _		Gender: Man □Women □ I identify as	
Phone:		<u>—</u>					
	Preferr	ed Lar	iguage of	commu	unication		
Aboriginal origin: Veteran:			U/K □ U/K □				
Cultural Needs:				specify	V		
Spiritual Needs:						_	
Is this person Capab Personal Care/Treat Contact Person		ıN□l	U/ <b>K</b> □		Property: Y Contact Pers	□ N □ U/K □	
(Name and rela	tionship))				(Name	e and relationship)	
(Addre	ess)					(Address)	
(Telep	hone)					(Telephone)	
Alternate Contact Po	erson:						
			(Name)			(Telephone)	
		(Addre	ss)			(Relationship)	
Are there any outsta	nding leg	al issu	es? (Pleas	e elabora	te)		

## Wendat Psychogeriatric Services Program – Referral Form

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History of Hospitalizations: (This refers to total # of previous admissions)

Psychiatric: # of admissions \_\_\_\_ Date of last admission/assessment \_\_\_\_\_

Primary Diagnosis: \_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

Psychiatrist: \_\_\_\_

Medical: # of admissions \_\_\_\_ Date of last admission/assessment: \_\_\_\_\_

Diagnoses: \_\_\_\_\_\_

Family Physician: \_\_\_\_\_ (Name)

(Address) (Telephone)

Medications: (Prescribed, OTC and Herbal): Please Attach

Allergies: \_\_\_\_\_

Falls Risk Assessment result: Date completed:

Reason for Referral: You may wish to attach a referral narrative that describes more accurately the client's situation which led to considering a referral for this service.

Risk Behaviours identified:	Factors Impacting Behaviours:				
	Priority Areas:				
	☐ Harm to self/other ☐ Abuse/neglect				
	□ Repeat E.D. visits □ Recent psych adm				
	☐ Increased substance use				
	□ Complicated grief/loss				
	Additional psychosocial stressors present:				
	□ Caregiver stress □ Legal				
	□ Problems with relationships □ Housing				
Prospective Discharge date, Location and	☐ Hx Substance abuse ☐ Memory Problem				
accommodation (shared or private):	□ Co-morbid medical issues				
<u></u>	☐ Psychiatric Illness symptoms				
	□ Social Isolation/activation				
	□ Behavioural changes				
	□ Other				

## Wendat Psychogeriatric Services Program – Referral Form

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Formal Supports/							
$\Box$ CCAC	□ Alzheimer'	S			□ Home	emaker	
□ CMHA	□ Waypoint		□ ACT		□ COA		
□ CNIB						ces Consultants	
□ Rehab	□ Wendat Int				$\square$ No S		
□ Complianc	□ Compliance □ Other Community Engagement:						
Informal Supports  □ Family  □ Other				□ Volu	nteers	□ No Supports	
Present accommo	dation:						
☐ Private ho	ouse/apt $\square$ Re	etirement Ho	me	□ Long	Term Ca	re	
	☐ Homes for Special Care ☐ Ontario Housing						
	☐ Group Home ☐ Mental Health U			Unit ☐ Continuing Complex Care			
□ General H	losp □ He	omeless		□ Hoste	el/Shelter		
Concerns re	lated to housing situ	nation:					
Living Arrangeme	ent:						
	□ With Paren use □ With Friend ed caregiver	•		Children Other Fa			
Highest level of E	Education attaine	ed:					
□ No formal	☐ No formal Schooling ☐ Some Elementary/Junior High ☐ E.				☐ Elementary/Junio	r High	
☐ Some Seco	☐ Some Secondary/High School ☐ Secondary			h School		□ Some College/Un	niversity
□ Communit	□ Community College □ Univer					☐ Other:	
□ Unknown	or Service Recipient I	Declined					
Primary Income S	Source:						
□ Employme	ent $\square$ E	mployment In:	surance	□ Pens	ion	□ ODSP	
☐ Social Ass	istance □ D	☐ Disability Assistance		☐ Family		☐ No Source of Inco	ome
□ Other	□ U	nknown or Se	rvice Red	cipient Dec	elined		
Is the person awa	re of this referra	1?	□ <b>Y</b>	□ N	□ U/K	-	
Has consent been	obtained?		$\Box$ Y	$\square$ N	□ U/K	-	

Documents included in Referral Package:					
□ Power of Atto	□ Power of Attorney (a copy if client is not capable to provide consent)				
□ Consent for □	Disclosure of Personal Health Information (Verbal or Written)				
□ History/consu	alts – Medical, Psychiatric, Social, Neurological				
□ OT/PT Asses	sments				
□ Cognitive test	ting and results				
	<ul> <li>□ Lab</li> <li>□ MARS</li> <li>□ X-ray, Diagnostic imaging (CT, MRI, etc)</li> </ul>				
•	ssisting us in assuring that the service we provide is effective, efficient to the needs of our mutual client as well as their formal and informal				
Please forward the completed referral form to: Zina Thomson, Program Supervisor Wendat Community Programs 44 Dufferin St.Penetanguishene, ONT L9M 1H4 FAX: (705) 355-1026 WEBSITE: www.wendatprograms.com The Program Manager can also be reached by telephone Monday to Thursday 9AM - 5PM at 705-355-1022 ext 228					
	OFFICE USE ONLY				
Date referral receive Intake Outcome:					
Assigned to:					