

**GERIATRIC PSYCHIATRY COMMUNITY SERVICE – BAYCREST HOSPITAL**  
**INTAKE FORM**

**Client Information**

Name \_\_\_\_\_ m[ ] f[ ]  
Surname Given Name Gender

Address: \_\_\_\_\_  
Street apt. #

\_\_\_\_\_ City Postal Code

Phone: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
D M Y

OHIP Number: \_\_\_\_\_

**Family/Caregiver Contact:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone numbers: \_\_\_\_\_  
Home

\_\_\_\_\_ Work Cell.

**Referral Information**

Name of Referrer: \_\_\_\_\_

Agency/Relationship \_\_\_\_\_

Phone# ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

**Family Physician** (if not the source of referral)

\*\*MD aware of referral: yes [ ] no [ ]

Name \_\_\_\_\_

Phone# \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Current psychiatrist involvement \_\_\_\_\_

Past psychiatric involvement \_\_\_\_\_

**Reason for Referral**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(over)

Date of Referral \_\_\_\_/\_\_\_\_/\_\_\_\_  
D M Y

Meditech#: \_\_\_\_\_

Intake Worker: \_\_\_\_\_

Catchment Area: yes [ ] no [ ]

If not, specify area \_\_\_\_\_

Consent of Client yes [ ] no [ ]

Consent of SDM/POA \_\_\_\_\_  
Name

Consent to contact family yes [ ] no [ ]

Language[s] \_\_\_\_\_

Interpreter needed? \_\_\_\_\_

Hearing impaired? yes [ ] no [ ] Device? yes [ ] no [ ]

Marital Status single [ ] married [ ] widowed [ ] divorced [ ]  
separated [ ] other \_\_\_\_\_

Living arrangement: alone [ ] with spouse [ ] with others [ ]

Accommodation: private home or apartment [ ] nursing home [ ]  
retirement home [ ] other [ ] Specify \_\_\_\_\_

**Other Baycrest/community services involved:**

\_\_\_\_\_  
\_\_\_\_\_

**Potential Safety Risks for visits (office or home):**

aggressive behaviour [ ] sexually inappropriate behaviour [ ]

communicable diseases [ ] hazards in the home [ ]

other people in the home [ ] pets [ ] smoking [ ] other [ ]

Comments: \_\_\_\_\_

\_\_\_\_\_

Is client able to come to Baycrest if needed? yes [ ] no [ ]

**Intake Outcome**

[ ] inquiry only  
[ ] redirected to other service, specify: \_\_\_\_\_  
[ ] admit [ ] re-open  
[ ] cancel - reason: \_\_\_\_\_

Date Assigned: \_\_\_\_\_

Case co-ordinator: \_\_\_\_\_

Admin: Meditech reg. \_\_\_\_\_ Other Baycrest charts \_\_\_\_\_ MD referral sent \_\_\_\_\_

Case Co-ordinator: appt. fax for MD \_\_\_\_\_ assessment form \_\_\_\_\_ discharge \_\_\_\_\_

