Outpatient Services Centralized Intake Referral Form

Attach patient demographics label here

Please fax referral and related documents to fax: 647-788-2199

We are not crisis or emergency services. If your client needs immediate help, please direct them to the nearest emergency dept or call 911

Name of Patient (Last Name/First Name)	DOB (dd/mm/yyyy)	Gender ☐Male ☐Female ☐Other

Street Name and Number	City	Province	Postal Code

Home Phone	Other phone	Preferred Language? ☐English ☐ Other _____ Interpreter required? ☐Yes ☐No	Health Card Number	Version Code

Primary Contact(Last Name/ First Name)	Phone Number	Relation to Patient	Who should be contacted first? ☐Patient ☐Family ☐Other Tel.

Is the patient homebound? ☐Yes ☐No | **Has the patient/SDM been informed of and consented to referral? ☐Y ☐N**

Safety concerns for providers: ☐Smoking ☐ Pets ☐Infestations ☐Infections ☐Weapons ☐Substance Abuse ☐Other_____ ☐ Not sure

INSTRUCTIONS: Please Indicate the reason for referral and complete the medical information section and check preferred services. Please note that during the referral review process, patients may be redirected to the most appropriate service (s)

Reason(s) for referral

Medical/physical
- ☐ Frail
- ☐ Mobility/Falls
- ☐ Incontinence- Bladder/Bowel
- ☐ Nutrition/ Appetite
- ☐ Pain Management
- ☐ Medication/Polypharmacy
- ☐ Weight Loss_____Kg/lb
- ☐ Multiple Comorbidities

Cognitive/Behavioral
- ☐ Delirium
- ☐ Verbal/Physical Aggression
- ☐ Agitation/Wandering
- ☐ Delusions/Hallucinations
- ☐ Apathy
- ☐ Depression/Anxiety
- ☐ Suicidal ideation
- ☐ Bereavement
- ☐ Sleep Problems
- ☐ Memory Loss
  - ☐Mild ☐Mod. ☐Severe
- ☐ Language Difficulties
  - ☐Mild ☐Mod. ☐Severe
- ☐ Mild Cognitive Impairment (MCI)

Psychosocial
- ☐ Caregiver/Family Concerns
- ☐ Suspected Abuse/Neglect
- ☐ Social Isolation

Functional
- ☐ ADL/IADL Decline
- ☐ Home Safety
- ☐ Driving Safety

Medical Information

Please provide a brief history of reason for referral/identify primary concern and comorbidities (if applicable)

Primary Concern:

Active co-morbidities/co-factors:

Medical History

Please attach the following information:
- ☐ Patient Profile
- ☐ Past Medical History
- ☐ Medication list /Allergies
- ☐ Test results (including cognitive scores, lab and imaging results)
- ☐ Relevant Consultation reports (e.g., cardiology, neurology, geriatrics, psychiatry, neuropsychology, and cognitive testing)
- ☐ Coordinated Care Plan

Preferred Service(s)

Geriatric Medicine
- ☐ **Outreach: Homebound ONLY- Integrated Community Care Team (ICCT)**
- ☐ **Clinic: Geriatric Assessment Clinic**
  - ☐First Available Appointment
  - ☐ Dr. _____Only
- ☐ **Day Treatment Centre**

Geriatric Psychiatry
Current Psychiatrist Name(if applicable)

- ☐ **Outreach: Geriatric Psychiatry Community Outreach (GPCS)**
  - ☐ Case Management
  - ☐ **Home Visit – First Available**
  - ☐ **Home Visit- Dr** _____Only
- ☐ **Clinic: Ambulatory Mental Health**
  - ☐ First Available Appointment
  - ☐Dr_____Only
- ☐ **Psychiatric Day Hospital**
  - ☐ Two-day Program ☐Four-day Program

Specialized Memory
- ☐ **Sam & Ida Ross Memory Clinic**
  - ☐First Available Appointment
  - ☐ Dr. _____Only

Multidisciplinary
- ☐ **Interprofessional Primary Care Team (IPCT)**

Other
- ☐ **Not Sure**

Name of Family MD	Last Assessment Date	Telephone	Fax

Space for Referring MD label/stamp(Optional)

Referring source information

Name of Referring Physician/NP/Healthcare Professional	Telephone	Fax
Signature of Referring Physician/NP/Healthcare Provider	**Billing#**	**Date (dd/mm/yyyy)**

Incomplete referrals will result in delay of services as they cannot be processed until all information is received

Email Form | Reset Form | Print Form