The Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

Geriatric Inpatient Referral Form

Please return the completed and signed referral form by Fax to 613-798-2999.

Please contact the Geriatric Intake Admin at (613) 722-6521 x 6637 or the email address above if you have any questions

We will review all referrals for geriatric inpatient unit admissions at The Royal. The referring geriatric psychiatrist will be advised about the outcome of the referral. For patients not currently followed by ROMHC, referring geriatric psychiatrist MUST discuss with inpatient clinical director at (613) 722-6521 ext. 6637

PATIENT INFORMATION

Date of Referral: DD / MM / YYYY

Name (Last, First): _____

Health Card #: _____ Version #: _____

Date of Birth: DD / MM / YYYY Sex: ❑ Male ❑ Female ❑ Identified as: _____ *(Please specify)*

Mother's Maiden Name (Required by MOH): _____

Former/Maiden Surname: _____

Language of service: ❑ English ❑ French ❑ Other: _____ Interpreter required? ❑ Yes ❑ No

Patient Address: _____

City: _____ Postal Code: _____

Telephone (Cell): _____ Telephone (Home): _____

Email: _____

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Patient Name: _____ DOB: DD / MM / YYYY

REFERRING GERIATRIC PSYCHIATRIST

Name of Referring Geriatric Psychiatrist (and Outreach Team): _____

Telephone: _____ x _____ Fax: _____

Address: _____

Name of Family Physician/General Practitioner: _____

Address: _____

Telephone: _____ Fax: _____

GOALS OF ADMISSION

PSYCHIATRIC DIAGNOSIS *(suspected or known)*

Priority Level: ❑ Elective *(very ill and requiring inpatient assessment/treatment)* ❑ Urgent *(Imminent risk to self or others)*

LEGAL INFORMATION

NEXT OF KIN/POA

Name: _____ Relationship: _____

POA ❑ Yes ❑ No

Address: _____

City: _____ Postal Code: _____

Telephone: (Home) _____ (Cell) _____

IS PATIENT OR POA CONSENTING TO INPATIENT ADMISSION? ❑ Yes ❑ No

CARE DIRECTIVES *(DNR status)* _____

Patient Name: _____ DOB: DD / MM / YYYY

MEDICAL INFORMATION

PERTINENT MEDICAL HISTORY – *Please indicate full name and contact information*

Previous Psychiatric Assessment ❑ Yes ❑ No By whom? _____

Please obtain reports if yes

Allergies: ❑ No ❑ Yes If yes, please list: _____

Substance Use *(suspected or known)* – Please describe in detail if patient has current or a history of substance use. Indicate when, how long, quantity, frequency and drug used. Please repeat for each occurrence of drug used and/or major changes to usage (e.g. withdraw, relapse). Attach sheet if necessary.

SENDING FACILITY *(To be completed by referring source)*

Where is the patient coming from? *(Specify below)*

❑ Home ❑ Long-term care ❑ Hospital ❑ Other: _____

Facility Name: _____

Unit: _____

Contact Person: _____

Telephone: _____

Facility agrees to accept patient back: ❑ Yes ❑ No

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Patient Name: _____ DOB: DD / MM / YYYY

REFERRAL FORM MUST HAVE APPROPRIATE SIGNATURE FOR COMPLETION

Background information attached: Relevant info. ie. Blood work, CT scans, X-ray reports, medications tried, admission/discharge information from chronic care hospital, consults by geriatric Medicine, psychiatry or other specialties. If involuntary, please indicate current MHA form:

Admission criteria reviewed ❑ Yes ❑ No

Person is medically stable ❑ Yes ❑ No

If the patient's medical stability status changes, please notify us

Date: DD / MM / YYYY **Completed by:** _____

Signature and designation: _____

THE ROYAL USE ONLY

Date of Referral: DD / MM / YYYY

Referral: ❑ Accepted ❑ Declined

By: ❑ Clinical Lead ❑ MPCS

If declined, reason: ❑ Medical instability ❑ Does not meet admission criteria

❑ Other: _____

Admission prepared by admin (initials): _____