WENDAT SERVICES FOR SENIORS

Psychogeriatric Services Program
Referral Form – TRANSITION SERVICE

Referred by:
Organization name and address:
_____
_____
_____

Date of Referral: _____
Referral Contact:
Name: _____
Phone #: _____
Fax # _____

Client Information:

Client name: _____ DOB: _____ HC# _____

Address: _____ Marital Status _____ Gender: Man □Women □ I identify as_____
_____

Phone: _____ Language first spoken _____
Preferred Language of communication _____

Aboriginal origin: Y □ N □ U/K □
Veteran: Y □ N □ U/K □
Cultural Needs: Y □ N □ U/K □ specify _____
Spiritual Needs: Y □ N □ U/K □ specify _

Is this person Capable for:
Personal Care/Treatment: Y □ N □ U/K □
Contact Person

_____
(Name and relationship))

_____
(Address)

_____
(Telephone)

Property: Y □ N □ U/K □
Contact Person

_____
(Name and relationship)

_____
(Address)

_____
(Telephone)

Alternate Contact Person: _____ _____
(Name) (Telephone)

_____ _____
(Address) (Relationship)

Are there any outstanding legal issues? (Please elaborate) _____

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:**
Prospective Discharge date, Location and accommodation (shared or private):	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 □ Hx Substance abuse □ Memory Problem □ Co-morbid medical issues □ Psychiatric Illness symptoms □ Social Isolation/activation □ Behavioural changes □ Other _ _____

Formal Supports/Services Involved:

□ CCAC □ Alzheimer's □ Day Out □ Homemaker
□ CMHA □ Waypoint □ ACTT □ COAST
□ CNIB □ Respite □ Psychogeriatric Resources Consultants
□ Rehab □ Wendat Internal Referral □ No Supports
□ Compliance □ Other Community Engagement: _____

_____

Informal Supports Involved:

□ Family □ Friends □ Neighbors □ Volunteers □ No Supports
□ Other _____

_____

Present accommodation:

□ Private house/apt □ Retirement Home □ Long Term Care
□ Homes for Special Care □ Ontario Housing □ Supportive Housing
□ Group Home □ Mental Health Unit □ Continuing Complex Care
□ General Hosp □ Homeless □ Hostel/Shelter
Concerns related to housing situation: _____

_____

Living Arrangement:

□ Alone □ With Parents □ With Children
□ With Spouse □ With Friend □ With Other Family
□ Non-related caregiver

Highest level of Education attained:

□ No formal Schooling □ Some Elementary/Junior High □ Elementary/Junior High
□ Some Secondary/High School □ Secondary/High School □ Some College/University
□ Community College □ University □ Other: _____
□ Unknown or Service Recipient Declined

Primary Income Source:

□ Employment □ Employment Insurance □ Pension □ ODSP
□ Social Assistance □ Disability Assistance □ Family □ No Source of Income
□ Other □ Unknown or Service Recipient Declined

Is the person aware of this referral? □ Y □ N □ U/K

Has consent been obtained? □ Y □ N □ U/K

Documents included in Referral Package:

□ Power of Attorney (a copy if client is not capable to provide consent)

□ Consent for Disclosure of Personal Health Information (Verbal or Written)

□ History/consults – Medical, Psychiatric, Social, Neurological

□ OT/PT Assessments

□ Cognitive testing and results

□ Recent: □ Lab
□ MARS
□ X-ray, Diagnostic imaging (CT, MRI, etc)

Thank you for assisting us in assuring that the service we provide is effective, efficient and appropriate to the needs of our mutual client as well as their formal and informal support system.

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 received: _____ Date Intake screen: _____
Intake Outcome: _____ Service Assignment date: _____

Assigned to: _____