North York General Hospital
Including the IODE Children's Centre
Embracing Health

GERIATRIC PSYCHIATRY REFERRAL FOR LONG TERM CARE FACILITIES

RGP

TEL: (416) 756-6050 FAX: (416) 756-3144

Name of Resident: _____ ☐ M ☐ F
surname *first name*

Name of Facility: _____ **Room #** _____ **Date of Admission** _____
d / m / y

Phone #: _____ **Marital Status:** _____

Health Card #: __ __ __ __ / __ __ __ / __ __ __ __ __ **DOB** _____
version code *d / m / y*

Next of Kin /SDM _____ **Phone #:** _____
daytime number

Facility Contact Person: _____ **Phone/Ext** _____

Resident/substitute decision maker agreeable to referral ☐ **Yes** ☐ **No (please explain)**

please complete in full

Reason for Referral (*please check all appropriate problem categories*)

- ☐ behavioural difficulties
- ☐ caregiver stress
- ☐ cognitive impairment
- ☐ delusions/hallucinations
- ☐ depression/anxiety
- ☐ medication
- ☐ psychosocial
- ☐ suicidal ideation/attempts
- ☐ verbal/physical aggression
- ☐ wandering
- ☐ weight loss/nutrition
- ☐ Other

Main Concerns:

Brief History/Onset of Problem(s):

MMSE completed	☐ **NO**	☐ **YES**	**Score:**	
Depression Scale completed	☐ **NO**	☐ **YES**	**Score:**	
PIECES Resource Person in LTCH	**Name:**			
	Contact Info:			
Name of Referring MD (*please print*)				
Signature of Referring MD			**Date:**	**day/month/year**