St. Peter's Hospital
HAMILTON HEALTH SCIENCES

Centre for Healthy Aging Specialized Geriatric Outreach Referral

Long Term Care Homes
- Communities of Hamilton -
Phone: 905-521-2100 x 12397
Fax: 905-549-7003

Please ensure the following information is included with your faxed referral:

- ☐ Complete resident demographics including contact information for family/SDM contact
- ☐ Valid health card number
- ☐ Current medication – MAR/ EMAR
- ☐ Copy of Progress Notes last 4 weeks
- ☐ Signature of Attending Physician/Copy of Physician Order
- ☐ Relevant investigations (e.g. blood work, head CT/MRI, ECG) and relevant consults (e.g. geriatrician, psychiatry, neurology), as applies
- ☐ BSO Mobile LTC Team Initial PIECES Assessment (if there is/was BSO involvement)

Specialty Required: ☐ Geriatric Psychiatry ☐ Geriatric Medicine

Incomplete referrals will be returned to the Director of Care. Please call the office if URGENT.

Resident Information:

Surname: ______________ First Name ______________ M ☐ F ☐ Other ☐ Marital Status: ______________

Date of Birth ______________ (yyyy/mm/dd) Age ________ Health Care #: ______________ Version Code ________ Date of Admission to LTC ______________ (yyyy/mm/dd)

LTCH Facility Information:

Name of Long Term Care Home: ______________ Unit ______________

Facility Street Address: (Number and Name) ______________ City: ______________ Postal Code: ______________

Facility Phone: ______________ Facility Fax: ______________

Name of Person Completing Referral Form: ______________ Role: ______________ Contact Phone Number / Ext. ______________

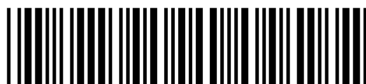
Printed Name of Attending Physician: ______________ Physician's Signature ______________ OHIP Billing Number: ______________

If capable, has the referred resident person consented to the referral? ☐ Yes ☐ No

OR

If resident is not capable, has the POA- PC or SDM consented to referral? ☐ Yes ☐ No

Name of POA-PC/SDM/Public Guardian: ______________ Relationship to Resident: ______________ Phone: ______________ Alternate Phone: ______________



Referrals *(Sovera document type)*

Centre for Healthy Aging
Specialized Geriatric Outreach
Referral

Long Term Care Homes
- Communities of Hamilton -
Phone: 905-521-2100 x 12397
Fax: 905-549-7003

Resident's Name ________________________________ Date (yyyy/mm/dd) ________________

Please describe the reason for the referral and specific expectations/ request. Include explanation of symptoms, onset and duration of concerns/behaviours: *(this field will expand to hold all text entered upon clicking outside of the box)*

____

Current Health Risks: **Please check the current health risks or concerns you have for the resident**

- ☐ Nutritional concern (e.g. recent weight loss within the past 3 months? Eating difficulties? Refusal to eat? Adverse changes?)
- ☐ Medication adherence/poly-pharmacy concerns or medication problems (e.g. adverse side effects, issues of compliance, > 5 medications?)
- ☐ Sleep disturbance problem or altered sleep pattern?
- ☐ Pain - recent onset or chronic pain
- ☐ Chronic medical conditions (e.g. thyroid, diabetes, cardiac, respiratory kidneys)
- ☐ Recent falls or mobility changes
- ☐ Other

Dressing:	**Bathing:**	**Feeding:**	**Continence Care:**	
☐ Independent	☐ Independent	☐ Independent	☐ Independent	☐ Incontinent Bladder
☐ Supervision	☐ Supervision	☐ Supervision	☐ Supervision	☐ Incontinent Bowel
☐ TotalAssist	☐ TotalAssist	☐ TotalAssist	☐ TotalAssist	

Communication:

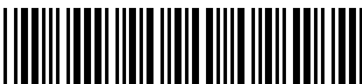
Preferred Language:
- ☐ English
- ☐ Other: ____________________
- ☐ Translator Needed
- ☐ Hearing Impaired
- ☐ Visually Impaired

Mobility or Transfer Aids:
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Mechanical Lift
- ☐ Other: ______________________

Does the resident have a psychiatric history or history of mental illness?

☐ Yes (please explain) ☐ No ☐ Unknown

____



Referrals *(Sovera document type)*

St. Peter's Hospital
HAMILTON HEALTH SCIENCES

Centre for Healthy Aging
Specialized Geriatric Outreach
Referral

Long Term Care Homes
- Communities of Hamilton -
Phone: 905-521-2100 x 12397

Resident's Name ________________________ Date (yyyy/mm/dd) ____________

Reason(s) for Referral and Risks (check all that apply):

- ☐ Suicidal
- ☐ Current/past homicidal ideation
- ☐ Memory impairment
- ☐ Depression (change in mood low)
- ☐ Mania (change in mood high)
- ☐ Delusions
- ☐ Hallucinations
- ☐ Wandering/leaving unsupervised/exit seeks
- ☐ Refusing or resisting care/treatment (refuses meds or therapies)
- ☐ Hoarding, collecting or rummaging/territorial
- ☐ Verbally responsive behavior-using obscenity, angry Expressions
- ☐ Physically responsive behavior-spitting, kicking, grabbing, pushing throwing, hitting others
- ☐ Other: ________________________

- ☐ Anxiety
- ☐ Agitation
- ☐ Substance misuse/ abuse Weight Loss
- ☐ Physical Decline
- ☐ Other: ________________________
- ☐ Sexual behaviour-suggestive remarks, grabbing, touching, exposing self
- ☐ High caregiver stress
- ☐ Resident on 1:1 or plan to initiate 1:1
- ☐ Police involvement or other crisis/recent ED visit for behaviours

Assessments/interventions tried or resources accessed:

☐ PRC Consulted ☐ BSO LTC Team involved ☐ NLOT or Nurse Practitioner Consulted

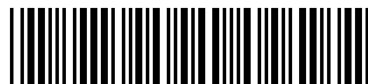
☐ Other interventions or resource: ________________________

Has the resident seen any specialists (e.g.Geriatrician,Psychiatrist,and/or other Mental Health provider) in the past?

☐ Yes ☐ No

Name of Specialist: ________________________

Phone: ________________________ Date of Consultation: (yyyy/mm/dd) ____________



Referrals *(Sovera document type)*