



**HURON PERTH SENIORS MENTAL HEALTH
& ADDICTION RESPONSE TEAM**

Community Mental Health Services
Box 309, 28 Centennial Drive, Seaforth, ON N0K 1W0
Phone: 519-527-8421 Ext 4821 / 4818
519-272-8210 Ext. 2570
Fax: 519-527-8420 / 519-272-8184



Connecting you with care
Votre lien aux soins

South West
CCAC CASC
Community
Care Access
Centre
Centre d'accès
aux soins
communautaires
du Sud-Ouest

Tel: 519-276-3400
1-855-276-3400
Fax: 519-273-2847

Reason for Referral

Please choose one organization. Fax referral to appropriate number above. Each organization will refer to each other as needed.

Alzheimer Society

- Education – for families, clients and professionals
- Support – for families, caregivers and persons with dementia
- “Safely Home” (Wandering Person’s Registry)
- Cognitive Decline
- Other

Seniors Mental Health

- Mental Health Issues
- Depression / Anxiety
- Cognitive Decline
- Responsive Behaviours
 - o Wandering
 - o Verbal Abuse
 - o Physical Abuse
 - o Public Disrobing
 - o Resists Care
- Socially Inappropriate/Disruptive
- Medication Review
- Addictions
- Other

Geriatric Resource Team

CCAC

- Respite/Placement
- Falls/Gait
- Continence
- Cognitive Decline
- Functional Decline
- Polypharmacy/Geriatric Medication Management
- Frequent ER Visits
- Weight Loss
- Pain
- Driving Issues
- Home Safety
- Failure to Thrive
- Other

Checklist for Long Term Care Facilities ONLY

Before you make a referral, have you considered treatment for the following:

- Is there an infection?
- Is the patient constipated?
- Has urinalysis / dip been completed?
- Did you do relevant blood work?
- Have you completed a chest assessment?
- Is the patient dehydrated?
- Has the patient had a recent fall?
- Has the patient been assessed for pain?
- Has the patient started any new medications recently?
- Could symptoms be medication side effects?

CLIENT: _____

Name of Client: _____ F M

DOB: _____ Healthcard: _____
dd/mm/yy

Address: _____
Street Number & Name

_____ Postal Code: _____
City, Province

Phone: _____ Marital Status: _____

Family Physician: _____ Phone: _____

Family Physician is aware & in agreement with referral: Yes

*** This is a requirement for involvement with Huron Perth Seniors Mental Health & Addiction Response Team*

Next of Kin/POA: _____ Phone: _____

Is the client/substitute decision maker aware & in agreement with this referral? Yes

When booking the initial assessment, make the arrangements with:

Client or Next of Kin/POA

CCAC Involved? Yes No

Seniors Mental Health Involved? Yes No

Alzheimer Society Involved? Yes No

CLIENT: _____

****COMPLETE LABORATORY WORK-UP REQUIRED FOR REFERRAL TO HURON PERTH SENIORS MENTAL HEALTH & ADDICTION RESPONSE TEAM AND GERIATRIC RESOURCE TEAM.**

(LAB RESULTS TO BE WITHIN THE LAST THREE MONTHS)

- CBC
- TSH
- Electrolytes, BUN, Creatinine, Uric Acid
- Calcium, Phosphorus
- Glucose
- Vitamin B12, Folate
- Liver Function: AST, ALT, GGT, Alk, Phos, Bilirubin, Albumin, Total Protein, Prothrombin Time
- Urinalysis
- ECG
- Chest X-Ray
- CT (rule out CVA or space occupying lesion if referral is due to cognitive impairment)
- Height & current weight
- Weight loss / gain over time _____

Also required:

ALL MEDICAL HISTORY, LAB RESULTS & ANY INFORMATION which may be relevant to the referral, if available.

Referral Completed by: _____

Phone Number of Referral Source: _____

Position: _____

Date: _____ Time: _____

For Office Use:

Date Received: _____ Time Received: _____

Clinician Assigned: _____