Alzheimer Society
HURON COUNTY
Tel: 519-482-1482 1-800-561-5012
Fax: 519-482-8692

Alzheimer Society
PERTH COUNTY
Tel: 519-271-1910 1-888-797-1882
Fax: 519-271-1231

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
  - ○ Wandering
  - ○ Verbal Abuse
  - ○ Physical Abuse
  - ○ Public Disrobing
  - ○ 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?

_____

_____

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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: _____

MEDICAL INFORMATION: Past and present; including past and current medications:

FOR LTC - TWO WEEKS DOCUMENTATION REQUIRED with referral and please include DOS charting:

Important medical history to be provided by referral source:

- ☐ Hearing/vision impairment
- ☐ History of substance misuse
- ☐ History of falls
- ☐ Mobility
- ☐ Osteoporosis
- ☐ Pain
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Urinary/Fecal incontinence
- ☐ Home safety
- ☐ Driving
- ☐ History of elder abuse

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: _____

Revised 17/02/14