Carewest
INNOVATIVE HEALTH CARE

Referral to Geriatric Mental Health Unit
At Carewest Glenmore Park

Ph: 403-258-7672 / Fax: 403-258-7678

Do not thin from chart

Referral Party Information

Date referral sent (YYYY/MM/DD):

Client current location:

Current location telephone:

Referring party name:

Referring party telephone:

Affiliation of Referring party
- ☐ RGH
- ☐ GMHOT (Geriatric Mental Health Outreach Team)
- ☐ RGH via Consult Liaison Service/Mental Health Geriatric Team
- ☐ PLC/SHC/FMC Adult Psychiatry Unit (specify)
- ☐ PLC/SHC/FMC Psychiatry Consultation Liaison Service (specify)
- ☐ Community Geriatric Mental Health
- ☐ Other

Name of Physician:

Name of referring psychiatrist:

Client Demographics

Client last name:

Client first name:

Date of birth:

Provincial Health Number:

Gender:

Marital status:

Legal status

Does the client have a legal guardian or enacted personal directive? ☐ Yes ☐ No

If yes, has the legal guardian or agent been notified of this referral? ☐ Yes ☐ No

Reasons for referral

Please describe client's goals/objectives for this admission and any specific expectations for the mental health rehabilitation and recovery program and treatment team:

For all referrals

Please send with the referral form when available:

☐ Recent psychiatric history - **Mandatory**

☐ Recent medical history - **Mandatory**

☐ List of current medications - **Mandatory**

☐ Rehabilitation/therapy assessments

☐ Treatment plan

☐ Other _____

Does the client meet admission criteria as indicated on the Alberta Referral Directory? Yes ☐ No ☐

Is the client aware of and in agreement with the referral into an in-patient, short-term rehabilitation and recovery program? Yes ☐ No ☐

Relevant History (please summarize or attach as indicated):

Medical history:

Psychiatric history:

Any current out-patient mental health follow-ups? Please identify, i.e. GMHOT, CGMH, etc.:

Discharge Planning:

Proposed Discharge Disposition:

Community supports available post-discharge:

Current Mental Health Diagnosis:

DSM-5 Psychiatric Diagnosis:

a) Primary DSM-5 Diagnosis:

b) Secondary DSM-5 Diagnosis (if applicable):

Psychosocial stressors:

Issues affecting treatment planning and care:

Substance abuse: ☐ Yes ☐ No ☐ Current? If current, detail: _____

Active substance withdrawal or unmanaged medical issues: ☐ Yes ☐ No Detail: _____

Aggressive/dangerous: ☐ Yes ☐ No ☐ Current? If current, detail: _____

Disruptive: ☐ Yes ☐ No ☐ Current? If current, detail: _____

Suicidal ideation: ☐ Yes ☐ No ☐ Current? If current, detail: _____

Actively suicidal: ☐ Yes ☐ No If yes, detail: _____

Hallucinations: ☐ Yes ☐ No ☐ Current? If current, detail: _____

Delusions: ☐ Yes ☐ No ☐ Current? If current, detail: _____

Communication barriers: ☐ Yes ☐ No

English language proficiency sufficient to participate in group therapy (groups conducted in English): ☐ Yes ☐ No

Ability to transfer independently (no significant mobility assistance required): ☐ Yes ☐ No

Diagnosis of sub-acute depression or anxiety: ☐ Yes ☐ No

Smoker: ☐ Yes ☐ No

Oxygen use: ☐ Yes ☐ No

Risk of falls: ☐ Yes ☐ No

Stoma/Wound care: ☐ Yes ☐ No

Nutritional concerns: ☐ Yes ☐ No

Incontinent - bladder: ☐ Yes ☐ No

Incontinent - bowel: ☐ Yes ☐ No

Infection control issues: ☐ Yes ☐ No

Cognitive impairment: ☐ Yes ☐ No

	Independent	Requires Assistance
Mobility	☐	☐
Transfers	☐	☐
Bathing	☐	☐
Grooming	☐	☐
Dressing	☐	☐
Toileting	☐	☐

Describe current housing:_____

_____

Discharge disposition:_____

Cognitive ability to engage in group therapy: ☐ Yes ☐ No

Any recent cognitive screening (i.e. SLUMS, MOCA): _____

Motivated to participate in group therapy with minimum 4-6 weeks commitment: ☐ Yes ☐ No

Infection Control Management

MRSA: ☐ Yes ☐ No Culture pending: _____

VRE: ☐ Yes ☐ No Culture pending: _____

C Diff: ☐ Yes ☐ No Culture pending: _____

TB: ☐ Yes ☐ No Culture pending: _____

Other (specify): _____

Date of actual admission to Geriatric Health Unit (YYYY/MM/DD):

Consulting psychiatrist approval:

Name of consulting psychiatrist: _____

Has the consulting psychiatrists reviewed and approved this referral: ☐ Yes ☐ No

Date of approval (YYYY/MM/DD): _____