



GERIATRIC MENTAL HEALTH OUTREACH
TEAM (GMHOT) REFERRAL FORM

LTC HOMES ONLY
Fax to: 416-495-2426

Our catchment area is as follows:
The east side of Victoria Park Ave (Odd #'s only)
South to the lake
The west side of Markham Rd (even #'s only)
North up to Steeles Ave.



300373

Client: _____ Male Female
Surname First Name

DOB: _____
(dd/mm/yy) Age OHIP# VC Primary Language

Long Term Care Home Name: _____ *Contact Person Name: _____
Mandatory

Address City Postal Code *Contact Number

POA/SDM: Name: _____ POA/SDM Cell Number: _____

POA/SDM email: _____

Presenting Problem/Main Concern:

BPSD Diagnosis, secondary diagnosis if known:

- Depression
- Anxiety Disorder
- Bipolar
- OCD
- Schizophrenia
- Personality Disorder
- PTSD
- Development Delay
- Psychotic Disorder
- Other
- Substance Use

Current Medications:

Service Required:

- Behavioral Assessment
- Psychiatry Assessment
- Family Psychoeducation Program
- Recommendations

Has your patient been assessed by a psychiatrist within the last year? Yes No Unknown

(if yes, please provide discharge letter from current psychiatrist and consult notes, if any)

POA/SDM consented to referral

POA/SDM aware clinic is short-term

Physician Information:

Billing Number: _____

Referring Physician: _____

Telephone: _____

Fax: _____