GERIATRIC MENTAL HEALTH OUTREACH TEAM (GMHOT) REFERRAL FORM

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.

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 form current psychiatrist and consult notes, if any)

POA/SDM consented to referral ☐ **POA/SDM aware clinic is short–term** ☐

Physician Information:

Referring Physician: _____ **Billing Number:** _____

Telephone:_____ Fax: _____

PRINT RESET

Incomplete or illegible referrals may delay Service.