DEER LODGE CENTRE
Making lives better

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Geriatric Mental Health Team Referral Form

PH #: (204) 982-0140 FAX: (204) 982-0144

ASSIGNED TO: ☐ **RE/Trans** ☐ **SJ/Assin** ☐ **DT/PD**
(For Internal Use Only) ☐ **SO/Ink** ☐ **SB/SV** ☐ **RH/FG**

CLIENT SURNAME

GIVEN NAME

DATE OF BIRTH

SEX

MFRN #

PHIN #

DATE OF REFERRAL: _____ ☐ **URGENT, WHY?** _____
CLIENT'S NAME: _____ (M / F) PHONE #: _____
ADDRESS: _____ Rm. # _____ Postal Code: _____
MFRN #: _____ PHIN #: _____
DATE OF BIRTH: _____ AGE: _____ Languages Spoken: _____ Interpreter Required: _____
RESIDES WITH: ☐ Spouse ☐ Alone ☐ Other _____

AGENCIES INVOLVED: Psychiatrist: _____ Phone: _____ Fax: _____
Day Hospital _____ Mental Health _____ GPAT _____ Other _____
Home Care Coordinator: _____ Phone: _____ Fax: _____
Family Physician: _____ Phone: _____ Fax: _____
Address: _____ Postal Code: _____ Is Physician aware of concerns? ☐ YES ☐ NO
Legal/Financial Arrangements: ☐ Self ☐ Power of Attorney (POA) ☐ Committeeship ☐ Public Trustee
POA/Committeeship held by: _____ Phone: _____

TO ARRANGE APPOINTMENT, CALL: ☐ **CLIENT, or** ☐ **CONTACT(S)**
Primary Contact: _____ Relationship: _____ Phone: _____
Alternate Contact: _____ Relationship: _____ Phone: _____
Is client/family in agreement with referral? ☐ YES ☐ NO

GERIATRIC MENTAL HEALTH ISSUES: ☐ Anxiety ☐ Depression ☐ Behaviour ☐ Cognition ☐ Mental Health Issues/Diagnosis ☐ Caregiver Burden ☐ Medication ☐ Housing/Squalor ☐ Psychosocial Decline ☐ Abuse

DIAGNOSES & CURRENT MEDICATIONS (Please attach with Labs/Diagnostics & other reports): _____

DESCRIBE SITUATION: _____

EXPECTATION (QUESTION) FOR THE TEAM? _____

Duration of Problem: ☐ < 2 weeks ☐ 2 - 4 weeks ☐ 4 weeks - 6 months ☐ > 6 months

Date and location of last hospital admission or Emergency visit: _____

REFERRED BY: _____ **AGENCY:** _____ **Ph. #:** _____ **Fax:** _____