Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Older Adult Community Mental Health & Addictions
Referral Line: 604-709-6785
Fax: 604-709-6789

Please complete this form and fax with attachments to 604-709-6789.
NOTE: WE ARE NOT AN EMERGENCY SERVICE

Name of Client: (surname, first name)	**DOB:** (dd/mm/yyyy)	**PHN:**	**Male** ☐ **Female** ☐
Address or Facility Name:		**Phone Number:**	
Language of Care:	**Primary Contact Name:**	**Phone:**	
Referral Source:	**Referral Source Phone Number:**		
Family Physician:	**Family Physician Phone Number:**		
Date last seen by Family Physician: (dd/mm/yyyy)	**Family Physician supportive of referral: Yes** ☐ **No** ☐		

Reason for Referral: (Summary and attach additional page if necessary)

☐ **Consult Only** ☐ **Acute Issue**
☐ **Chronic Issue** ☐ **Addiction/Substance Abuse**
☐ **Extended Leave (attach all Form 4, 6, 15, 20)**
☐ **Affected by Anothers' Substance Use**

What has changed?

What has been tried?

Medical Diagnosis / Physical Health Issues (attach relevant information)

Psychiatric History (attach relevant consults)

Medications (attach list or MAR)

Have you ruled out Delirium?: Yes ☐ **No** ☐

A. Consider review of lab work in past 1 - 3 months
(CBC+diff, lytes, urea, Cr, Vit B12, Fasting Blood Sugar, AST, ALT, GGT, alk pho, TSH, total protein, urine R+M)
Attached: Yes ☐ **No** ☐

B. Relevant Investigations (eg. EEG, EKG, MRI)
Attached: Yes ☐ **No** ☐

Risks (check all the apply)

Adult Guardianship
- ☐ Verbal Abuse
- ☐ Physical Abuse
- ☐ Financial Abuse
- ☐ Selt Neglect

- ☐ Suicidal Ideation
- ☐ Treatment Non Adherance
- ☐ Polypharmacy

- ☐ Driving Safety
- ☐ Fire Risk
- ☐ Environment (Hoarding/Pests/Flooding)

- ☐ Firearms
- ☐ Falls

Associated Symptoms Psychiatric (Check all that apply)
- ☐ Depression
- ☐ Mania
- ☐ Anxiety
- ☐ Grief/Adjustment

- ☐ Hallucinations
- ☐ Delusions
- ☐ Paranoia/Suspiciousness

- ☐ Sleep Disturbance
- ☐ Memory Impairment / Dementia
  MOCA _____
  MMSE _____

- ☐ Confusion
  - ☐ Acute
  - ☐ Chronic

Behavioural
- ☐ Wandering/Pacing/Exit Seeking
- ☐ Physical Aggression

- ☐ Verbal Aggression (threats)

- ☐ Verbal Agitation (calling out)

- ☐ Sexual Behaviour
- ☐ Resistant to Care

Date of Referral (dd/mm/yyyy)	**PARIS ID** (For VCH Office Use Only)

OLDER ADULT COMMUNITY MENTAL HEALTH REFERRAL FORM