

Please ensure your patient has provided consent for this referral

PATIENT INFORMATION
CONTACT PERSON / NOK

Last Name:		Last Name:	
First Name:		First Name:	
Phone:		Phone:	
DOB (m/d/y):		Relationship to Patient:	
Gender: ☐ M ☐ F ☐ Other / Unknown		Pt PHN:	
Consent To Consult (Patient or NOK)? ☐ Y ☐ N		Extended Health Coverage? ☐ Y ☐ N	
Consent to Review Health Authority Records? ☐ Y ☐ N			

GP/NP INFORMATION

GP/NP:	
Telephone:	Fax:

Reason for Referral (Presenting Problems & Expected Outcome):
Medical Conditions & Surgeries:
Current Medications:
Allergies:
Current / Previous Psychiatric History:

Identified risk:	Concern	Identified risk	Concern	Identified Risk:	Concern
Health issues		Recent loss of loved one		Alcohol / substance use	
Cognitive changes		Recent stressful event		Driving concerns	
Aggression (physical / verbal)		Self-neglect		Financial abuse	
Behavioral changes		Mood changes		Physical abuse	
Suspiciousness / paranoia		Suicidal thoughts		Homeless or at risk	
Wandering		Disturbed sleep		Falls / Gait disorder	
Client lives alone		Appetite changes		Freq hospitalizations	
Firearm / Weapons / gun		Caregiver stress		Other	