UHN Toronto General Toronto Western Princess Margaret Toronto Rehab

Geriatric Telepsychiatry Referral Form

PLEASE COMPLETE THIS FORM AND SUBMIT WITH AN OTN TELEMEDICINE CLINICAL SCHEDULING FORM

Patient Name: _____Referral date _____/_____/_____

Date of Birth _____/_____/_____ Male Female

Interpreter needed? NO YES: Language _____

Any barriers to communication (ie sensory impairment): NO YES: _____

Reason for Referral : ☐Diagnostic clarification ☐Medication review ☐Treatment resistance ☐Safety assessment
Other:

Clinical problems:

Onset of Problem (indicate number): Weeks:_____ Months_____ Years:_____

Living Situation: ☐Home ☐Seniors apartment ☐Retirement home ☐Long term care facility
☐Other: _____

Lives with: ☐ Spouse ☐Other family ☐Alone ☐Other: _____

Functional concerns (check all that apply): ☐Driving ☐Falls ☐Mobility issues ☐Caregiver issues ☐Social isolation
☐Financial management ☐Medication management ☐ Aggression ☐Other safety concerns: _____

Community services involved (attach reports if available):

Past Psychiatric History:

Previous psychiatric admissions or consultations (please attach):

Name of current/ previous psychiatrist(s): _____

Addictions issues?: NO YES: _____

History of suicidality? NO YES: _____

Diagnosis of Dementia?: NO YES: _____

If available, most recent MMSE score _____ Date _____

Relevant Medical History: (list below or attach)

Most recent relevant labwork, ECG or neuroimaging (please attach reports):

Current medications: (list below or attach)

Known allergies: