

SELKIRK MENTAL HEALTH CENTRE
"We are a non-smoking facility"
REFERRAL FORM



Geriatric Program

Rehabilitation Program

I. PERSONAL DATA

Name: _____

Male Female

Address: _____

Telephone: _____

Date of Birth: _____

Marital Status: _____

Education: _____

Occupation: _____

MB Health #: _____

PHIN #: _____

Legal Status: Voluntary Involuntary

Form 9 If yes, treatment decisions by: _____

Form 10

Previous admissions to Selkirk Mental Health Centre?

Yes No

Order of Supervision If yes, date issued: _____

Source of income: _____

Social Allowance # _____

Next of Kin: _____

Relationship: _____

Address: _____

Telephone (home): _____

Telephone (bus.): _____

II. PSYCHIATRIC DATA

Psychiatric Diagnoses: _____

Onset: _____

Admissions: _____

Treatment: _____

Follow-up: _____

Previous involvement in any Rehab Program? _____

Indicate cooperation and response of client: _____

Psychiatrist: _____

Telephone: _____

Address: _____

III. MEDICAL DATA (*significant medical history such as allergies, seizures, disabilities, etc.*)

Diet (please specify):

Swallowing Assessment Completed?

No Yes (please attach)

Physician: _____

Telephone: _____

Address: _____

Medications and Treatments (*include name, dosage and compliance*):

Pnuemococcal Vaccine given?

No Yes _____
Date

Mantoux Test Completed?

No Yes _____
Date

Reading

History of BCG?

No Yes _____
Date

Current Level of Functioning

Behaviour:

Personal Care:

Mobility:

Abilities:

Interests:

Social Problems:

History of aggression:

Alcohol/substance abuse:

Suicidal ideation:

IV. SOCIAL DATA

Family Background

Relationships:

Family history of psychiatric illness:

Support systems:

Spiritual needs:

Education:

Employment/vocational history:

Family perceptions:

Family expectations:

Involvement with client/patient:

Community Placements

Number and list all placements tried:

Length of placement:

Reason for breakdowns:

Viable community placement options:

Preferences:

V. REFERRAL SOURCE

Name: _____ Position: _____

Address: _____ Telephone: _____

Reason for Referral: _____

What SMHC services do you feel are required for this client? _____

Is the client/patient agreeable to SMHC admission: Yes No

Is the family agreeable to SMHC admission: Yes No

Date referring facility met with family to discuss SMHC admission: _____

Does client/patient wish to tour the identified program at SMHC? Yes No

Does the family wish to tour the identified program at SMHC? Yes No

Is a C.M.H.W. involved in this case? Yes No

Name: _____ Region: _____

Telephone: _____

Please ensure the following are attached in order to assist the review teams with making a decision regarding the referral:

- 1. Significant medical/psychiatric reports
- 2. Detailed social history
- 3. Psychological assessment
- 4. Occupational Therapy assessment

Signature of referring source

Date

Please complete and forward to the appropriate program by mail (DO NOT FAX)

Program Manager
Geriatric Program
Selkirk Mental Health Centre
Box 9600
Selkirk MB R1A 2B5

Program Manager
Rehabilitation Program
Selkirk Mental Health Centre
Box 9600
Selkirk MB R1A 2B5