Selkirk Mental Health Centre
Geriatric Rehabilitation Program Referral Form
We are a non-smoking facility

Date of Application ______/______/______
(day/month/year)

Is the applicant/legal decision makers aware that you are making the referral? Yes ☐ No ☐ **(if no please explain why)**

Applicant Information

Last Name:	First Name:	Initial:	Female ☐	Male ☐
Address:	Postal Code	Phone Number		
Date of Birth (DD/MM/YY)	MHSC#	PHIN#	Indigenous Treaty Status ☐ # ______________	

Legal Status & Financial Management

Voluntary ☐ Involuntary ☐

Form 9 ☐ If yes, treatment decisions by:________________________________

Form 10 ☐ ________________________

Order of Committee ☐ If Yes, date issued: ____________________

Person Responsible:______________________________________

Power of Attorney ☐ __________________________________

Next of Kin

Name: ______________________	Name: ______________________
Address: ______________________	Address: ______________________
Phone: H):______________________	Phone: H):______________________
C):______________________	C):______________________
Email: ______________________	Email: ______________________

Rehabilitation Goals / Reason for Referral

Psychiatric Data

Psychiatric Diagnosis	If yes what is the diagnosis?		History	Current
Yes ☐ No ☐	Diagnosis one: ______			
Don't know ☐	Diagnosis two: ______	Self-Harm	Yes ☐ No ☐	Yes ☐ No ☐
	Prior psychiatric admissions : ______	Suicidality	Yes ☐ No ☐	Yes ☐ No ☐

Behaviours of Concern		
	☐ Verbal aggression ______	Frequency: ______
	☐ Physical aggression ______	Frequency: ______
	☐ Exit-seeking ______	Frequency: ______
	☐ Confusion ______	Frequency: ______
	☐ Intrusiveness ______	Frequency: ______
	☐ Wandering ______	Frequency: ______
	☐ Sexual ______	Frequency: ______
	☐ Other ______	Frequency: ______
	☐ Other ______	Frequency: ______
Additional Information		

Medical Data

Current Diagnosis	Medical History

Prior Medical Admissions:

Vaccinations	Pneumococcal	COVID-19	TDaP	Influenza:
	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
	Date administered: ______	Type: ______ Date(s): ______	Date administered: ______	Date administered: ______

Pending Appointments:

Medications	**Please provide current MAR** Is the patient compliant?	Cpap use?	Allergies?	Is patient medically stable?
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ (List all)	Yes ☐ No ☐

Substance Use	Current ☐ History ☐ Last Use: ______ Type: ______

Diet	Details (type and texture):	Swallowing ax completed? Yes ☐ No ☐ (If yes, please attach copy) Dentures Y/N upper ☐ lower ☐ Are they worn? Yes ☐ No ☐

Activities of Daily Living: please explain care needs & attach any corresponding assessments	
Bathing and dressing	Independent ☐ Dependent ☐ # of staff required ______ Glasses? Yes ☐ No ☐ Explain ________________ Cooperative with care? Yes ☐ No ☐ Explain ______________________
Mobility & Transfers	Independent ☐ Dependent ☐ Transfer Status: __________________________ Falls? Yes ☐ No ☐ Explain: ________________ Cooperative with care? Yes ☐ No ☐ Explain: ________________ Restraints? Yes ☐ No ☐ Explain: ________________
Elimination	Continent ☐ Incontinent ☐ Independent ☐ Dependent ☐ Product size/type: ______________ Cooperative with care? Yes ☐ No ☐ Explain: __________________________
Community Service Use	
History of services used (attach any assessments from service providers)	Home Care ☐ Community Mental Health ☐ Name & Contact info for CMHW: ______________________ Outpatient psychiatry ☐ PACT ☐ Group Home ☐ MB Housing ☐ Assisted Living ☐ Mental Health Services for the Elderly ☐
Reason for service breakdown	Please explain:
Long Term Care	Is the patient panelled? No ☐ Yes ☐ Date of panel: __________________ Region: __________________ (**Please attach copy of panel application)**

Referral Source			
Name & Title	Facility	Address	Phone: ________________ Fax: ________________ Email: ________________
Name and Contact of treating physician (if available):			

Required documents:

1. *Significant Medical/Psychiatric reports*
2. *Mental Health Assessments*
3. *Integrated Progress Notes (2 weeks minimum)*
4. *Medication Administration Record*
5. *Recent medical exam*

Preferred documents (if available)

1. *Detailed social history*
2. *Allied Health assessments (OT, PT, SLP)*
3. *Behaviour Tracking (DOS, ABC)*
4. *Recent imaging or labs (within 6 months)*
5. *Psychological assessments*
6. *Most current Long Term Care application*

____
Signature of referring source

____
Date

Please complete and forward via **fax to 204-785-1507** or via mail to:

Program Manager
Geriatric Program
Selkirk Mental Health Centre
Box 9600, 825 Manitoba Ave
SELKIRK MB R1A 2B5