

**Selkirk Mental Health Centre
Geriatric Rehabilitation Program Referral Form**

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 <input type="checkbox"/>	Male <input type="checkbox"/>
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Address:	Postal Code	Phone Number
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Date of Birth (DD/MM/YY)	MHSC#	PHIN#	Indigenous Treaty Status <input type="checkbox"/> # _____
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Legal Status & Financial Management	Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/>
	Form 9 <input type="checkbox"/> If yes, treatment decisions by: _____
	Form 10 <input type="checkbox"/> _____
	Order of Committee <input type="checkbox"/> If Yes, date issued: _____
	Person Responsible: _____
Power of Attorney <input type="checkbox"/> _____	

Next of Kin	Name: _____	Name: _____
	Address: _____	Address: _____
	Phone: H): _____	Phone: H): _____
	C): _____	C): _____
	Email: _____	Email: _____

Rehabilitation Goals / Reason for Referral	
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Psychiatric Data

Psychiatric Diagnosis Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If yes what is the diagnosis? Diagnosis one: _____ Diagnosis two: _____ Prior psychiatric admissions : _____ _____	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">History</td> <td style="text-align: center;">Current</td> </tr> <tr> <td>Self-Harm</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Suicidality</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>		History	Current	Self-Harm	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Suicidality	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	History	Current									
Self-Harm	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>									
Suicidality	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>									

Behaviours of Concern	<input type="checkbox"/> Verbal aggression _____ Frequency: _____ <input type="checkbox"/> Physical aggression _____ Frequency: _____ <input type="checkbox"/> Exit-seeking _____ Frequency: _____ <input type="checkbox"/> Confusion _____ Frequency: _____ <input type="checkbox"/> Intrusiveness _____ Frequency: _____ <input type="checkbox"/> Wandering _____ Frequency: _____ <input type="checkbox"/> Sexual _____ Frequency: _____ <input type="checkbox"/> Other _____ Frequency: _____ <input type="checkbox"/> Other _____ Frequency: _____
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Additional Information	
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Medical Data

Current Diagnosis	Medical History

Prior Medical Admissions:

Vaccinations	Pneumococcal No <input type="checkbox"/> Yes <input type="checkbox"/> Date administered: _____	COVID-19 No <input type="checkbox"/> Yes <input type="checkbox"/> Type: _____ Date(s): _____	TDaP No <input type="checkbox"/> Yes <input type="checkbox"/> Date administered: _____	Influenza: No <input type="checkbox"/> Yes <input type="checkbox"/> Date administered: _____
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Pending Appointments:

Medications	**Please provide current MAR** Is the patient compliant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Cpap use? Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> (List all)	Is patient medically stable? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Substance Use	Current <input type="checkbox"/> History <input type="checkbox"/> Last Use: _____ Type: _____
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Diet	Details (type and texture): 	Swallowing ax completed? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please attach copy) Dentures Y/N upper <input type="checkbox"/> lower <input type="checkbox"/> Are they worn? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Activities of Daily Living: please explain care needs & attach any corresponding assessments			
Bathing and dressing	Independent <input type="checkbox"/> Dependent <input type="checkbox"/> # of staff required _____ Glasses? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain _____		
	Cooperative with care? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain _____		
Mobility & Transfers	Independent <input type="checkbox"/> Dependent <input type="checkbox"/> Transfer Status: _____		
	Falls? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____		
	Cooperative with care? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____		
Elimination	Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Independent <input type="checkbox"/> Dependent <input type="checkbox"/> Product size/type: _____		
	Cooperative with care? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____		
Community Service Use			
History of services used <small>(attach any assessments from service providers)</small>	Home Care <input type="checkbox"/> Community Mental Health <input type="checkbox"/> Name & Contact info for CMHW: _____		
	Outpatient psychiatry <input type="checkbox"/> PACT <input type="checkbox"/> Group Home <input type="checkbox"/> MB Housing <input type="checkbox"/> Assisted Living <input type="checkbox"/>		
	Mental Health Services for the Elderly <input type="checkbox"/>		
Reason for service breakdown	Please explain:		
Long Term Care	Is the patient panelled? No <input type="checkbox"/> Yes <input type="checkbox"/> Date of panel: _____ Region: _____ <p style="text-align: center;">(Please attach copy of panel application)</p>		
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