REFERRAL FORM FOR CONSULTATION

Name (Facility Point of Contact/BeST Team Lead) _____ Date of Referral _____

Email _____ Phone _____

*** Please fill out as much of the following as possible ****

Patient Name _____ DOB: (yyyy-mmm-dd) _____

Facility _____ Date of Admission _____

MRN _____ PHN _____

Allergies (if known) _____

Referring Physician _____

Referral Information: Reason for referral, who initially requested the referral (Physician? Nursing staff? Family? Patient?), **description** of problem or identified concerns:

Is the problem **new** (how long _____), or **longstanding**?

Comorbidities: What other **active** medical/psychiatric problems does the patient have?

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Past History: Medical and psychiatric diagnoses, hospital admissions

Family History: Age and cause of death of parents/siblings; cognitive impairment in parents or siblings? Any illnesses that run in the family?

Psychosocial History: Where born; general description of childhood (happy? difficult? abusive?); age/grade at leaving school; employment history; relationship history; trauma history; current social supports; POA? Rep Agreement? Advance Directive?

Cognitive/Mental Status:

	Current/Most Recent Score (*within 3 months*)		Any Previous Score/Date (*if available*):	
MMSE:	☐	Date: _____	☐	Date: _____
MOCA:	☐	Date: _____	☐	Date: _____
GDS:	☐	Date: _____	☐	Date: _____

Other:

Please fax completed form to (250) 755-6286 (Dr. Rusak)

January 2015 Dr. A. Rusak, Geriatric Psychiatry
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Nanaimo Division of Family Practice
A GPSC initiative