Erie St. Clair Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario d'Erié St. Clair

Sarnia-Lambton
System Navigator Referral Form

Name:
DOB *(dd/mm/yyyy)*:
HCN:
Other ID:

Reason for Referral: ☐ Transitional Support ☐ LTCH Referral (Lead Team) ☐ Community Referral
Previous Referral Made: ☐ YES ☐ NO

Responsive Behaviour/Personal Expression Overview

☐ Collecting/Rummaging
☐ Connection Seeking
☐ Distressed Behaviour (Agitated)
☐ Exploring/Searching (Exit Seeking, Pacing)
☐ Expression of Self Harm (Suicidal Ideation)
☐ Indiscriminate Ingestion of Foreign Substances
☐ Other:
☐ Physically Responsive Behaviour
☐ Refusing Care or Treatment
☐ Sexually Responsive Behaviour
☐ Suspicious or Paranoid Behaviour
☐ Verbally Responsive Behaviour
☐ Low Mood (contributing to health consequences)

Referral Source Information

CONSENT OBTAINED (Consent is required): ☐ **YES** ☐ **NO**

Name & Title:
Date of Referral:
Organization:
Phone:
Address:
Fax:

Individual Information (if different than above)

Address:
Phone:

Medical Information

Diagnosis:
Family Physician:
Has delirium been ruled out? ☐ **YES** ☐ **NO**
Is Individual acutely ill? ☐ **YES** ☐ **NO**

Recent Urinalysis Completed
☐ **YES**, results:
☐ **NO**, reason for not completing:

Recent Lab Work Completed
☐ **YES**, results:
☐ **NO**, reason for not completing:

Behaviour Assessment Checklist completed and attached?
☐ **YES**, date:
☐ **NO**, reason for not completing

First Contact Information

Name:
Phone:
Relationship to Individual:
POA Status & Name of POA:

Comments:

Fax Completed Form to: Alzheimer Society of Sarnia-Lambton **FAX 226-313-2049** PHONE 519-332-4444

PRINT Clear Form

Société Alzheimer Society
Canadian Mental Health Association Lambton Kent
Behavioural Supports Ontario

Created: 01JUL2012
Revised: 03JAN2025