



# Chatham-Kent System Navigator Referral Form

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

<b>Reason for Referral:</b>	Transitional Support	LTCH Referral (Lead Team)	Community Referral
Previous Referral Made:	YES	NO	
<b>Responsive Behaviour/Personal Expression Overview</b>			
Collecting/Rummaging	Other:		
Connection Seeking	Physically Responsive Behaviour		
Distressed Behaviour (Agitated)	Refusing Care or Treatment		
Exploring/Searching (Exit Seeking, Pacing)	Sexually Responsive Behaviour		
Expression of Self-Harm (Suicidal Ideation)	Suspicious or Paranoid Behaviour		
Indiscriminate Ingestion of Foreign Substances	Verbally Responsive Behaviour		
Low Mood (contributing to health consequences)			
<b>Referral Source Information</b>			
<b>CONSENT OBTAINED (Consent is required):</b>	<b>YES</b>	<b>NO</b>	
Name & Title:	Date of Referral:		
Organization:	Phone:		
Address:	Fax:		
<b>Client Information (if different than above)</b>			
Address:		Phone:	
<b>Medical Information</b>			
Diagnosis:			
Family Physician:			
Has delirium been ruled out?	<b>YES</b>	<b>NO</b>	
Is Client acutely ill?	<b>YES</b>	<b>NO</b>	
Recent Urinalysis Completed	Recent Lab Work Completed		
<b>YES</b> , results:	<b>YES</b> , results:		
<b>NO</b> , reason for not completing:	<b>NO</b> , reason for not completing:		
Behaviour Assessment Checklist completed and attached?			
<b>YES</b> , date:			
<b>NO</b> , reason for not completing:			
<b>First Contact Information</b>			
Name:		Phone:	
Relationship to Client:			
POA Status & Name of POA:			
Comments:			
<b>GMHOT/Psychiatric Support Required</b>			
	<b>YES</b>	<b>NO</b>	
Please Note: Geriatric Mental Health Outreach Team provides a shared-care service. Collaboration with a Primary Care Provider (LTC included) is required for consultative services. *			
*Please Include: Dementia Screen Bloodwork (CBC, BUN, Lytes, Liver Function, SED rate, Blood Sugar, Magnesium, Calcium, TSH, B12, Folate & Ferritin), ECG & Urinalysis, Current Medication List (inc. OTC & Homeopathic), Past Psychiatric or Specialist Consult Notes, and any other relevant information.			

**Fax Completed Form to: Alzheimer Society of Chatham-Kent      FAX 226-312-2239      PHONE 519-352-1043 x229**

