North Shore Older Adult Mental Health
#350– 145 West 17th Street
North Vancouver, BC, V7M 3G4
Tel: (604) 982-5600 Fax: (604) 982-5601

Office use only:
Date of referral received: _____
PARIS #

Inclusion criteria:

- A progressive cognitive or memory disorder with associated psychiatric and/or behavior management problems and/or co-occurring misuse of alcohol, prescription medications or other drugs
- A recently developed serious mental illness and physical or functional decline ie. Medical frailty
- A severe and persistent mental illness with cognitive, physical or functional decline

Exclusions:

- Individuals with non-progressive neurological disorders/ developmental disabilities
- Brain injury
- Stand alone capacity assessments
- Referrals made solely for medical/legal opinions or functional assessments for independent living

INCOMPLETE REFERRALS WILL BE RETURNED

Please contact OAMH Intake if you have any questions regarding potential referrals

GP/NP Name	GP/NP phone	GP/NP fax
Patient Name	DOB	Gender
Address	Telephone	PHN (if no PHN, please indicate reason)
Facility Name (if applicable)	Memory Care/LTC? Independent/Assisted Living?	Nursing Station Phone Number (and local)
Contact Person	Relationship	Telephone
Is patient/representative aware of this referral? ☐ Yes ☐ No	Additional information? (i.e. language, hearing, vision, interpreter)	

REASONS FOR REFERRAL (please send relevant notes if insufficient space on the referral form)

Please describe the mental health clinical question you would like OAMH to address (psychiatric, cognitive, behavioral, functional)	
Relevant medical and psychiatric history (including allergies, risk factors)- attach reports, lab results, MoCA, MMSE & MAR **PLEASE LIST ALL PSYCHOTROPICS TRIALED:**	
Do you want a consultation only? Please indicate specific request ie. medication recommendation/diagnostic clarification/etc:	
Have delirium/reversible causes been ruled out?	Last physical exam – (date and findings)
Recent stressors/precipitants/contributing factors	
Any other relevant information (ATTACH IF INSUFFICIENT SPACE HERE)	
Are there any RISKS TO OAMH STAFF associated with this referral? *(ie. behavioral, environmental)*	

GP/NP Signature _____ **Print Name**_____ **Date** _____ **MSP #** _____

Additional/Alternative Resources

RACE line: Available resource for GP for telephone consults only re: medication and/or treatment recommendations.
Mon-Fri, 0800-1700 T: 604-696-2131
VCH Home Health Central Intake: Clients that require assessment for LTC, OT, HCN, Home Supports **Fax: 604-983-6886**
Urgent and Primary Care Centre: For non-life-threatening illnesses or injuries not requiring ED visit.
Mon-Sat 0800-2200, Sun 0900-1700 T: 604-973-1600. 221 Esplanade West, 2nd Floor, North Vancouver.