St. Joseph's Healthcare Hamilton

SENIORS MENTAL HEALTH PROGRAM
Phone: 905-681-8233 ext. 222
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Fax: 905-681-8628

REFERRAL FOR LEARNING THE ROPES PROGRAM

Date of Referral: _____

Referring Physician: _____ Phone: _____

Patient Name: _____ HC # _____

D.O.B.: _____ Telephone Number: _____

Address: _____ City: _____ Postal Code: _____

Will someone be attending the group with this patient? ☐ Yes ☐ No

If yes, relationship of this person to the patient: _____

If someone other than the patient should be contacted regarding the start up of the Program , please provide the following information:

Name: _____ Relationship: _____

Phone Number: _____

Is the patient aware of the referral? ☐ Yes ☐ No

Current Diagnosis:

Who made the diagnosis of Mild Cognitive Impairment? _____

Date diagnosis made? _____

Is patient currently/previously involved with Specialist/Memory Program? ☐ Yes ☐ No

If yes, please provide name of Specialist/Memory Program _____

If available, please attach:
☐ Clinical reports
☐ Scans (CT, MRI)
Cognitive Scale scores: ☐ SMMSE_____ ☐ MoCA_____ ☐ Other: _____
Date: _____ Date: _____ Date: _____

FAX COMPLETED REFERRAL FORM TO HALTON SENIORS MENTAL HEALTH OUTREACH PROGRAM

FAX: 905-681-8628

EMAIL: epeterse@stjoes.ca