

PATIENT INFORMATION LABEL HERE

PATIENT ASSESSMENT

a) Is the ONLY reason for this referral one of the following:			
i. Driving fitness concerns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
ii. MAiD capability assessment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
iii. Assessing/treating alcohol or substance use disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Does patient have a history of traumatic or acquired brain injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
c) Does patient have complex mental health or substance use issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
d) Does patient have current adult psychiatry involvement, or follow up within the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
e) Does patient have a progressive neurodegenerative disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
f) Is primary concern memory loss / cognitive decline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

SAFETY CONCERNS

a) Is patient still driving?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
b) Are there medication management concerns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
c) Does patient have ongoing community supports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
d) Does patient live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

SUPPORTING COLLATERAL

*Information and diagnostics that are **recommended** to support this referral.*

Strongly recommended:	Included?
a) MRI Brain or CT Head (if within last 18 months). Date of most recent scan:	<input type="checkbox"/>
b) Past medical history	<input type="checkbox"/>
c) Medication list	<input type="checkbox"/>
d) Copy of actual MoCA/MMSE or other cognitive assessments (full page)	<input type="checkbox"/>
e) Neurology or other specialist consult notes relevant to referral, if not available in PowerChart	<input type="checkbox"/>
As appropriate:	
a) Other test results: CBC, lytes, urea, creatinine, HbA1C, TSH, B12 level, ionized calcium or calcium and albumin, eGFR, copy of most recent ECG.	<input type="checkbox"/>
b) MOST	<input type="checkbox"/>

FAX ROUTING

Fax referral and supporting documents to the appropriate Community Access location

REGION	FAX	PHONE
South Island	250-519-5288	250-388-2273
Central Island	250-739-5751	250-739-5748
North Island	250-331-8569	250-331-8530

