Avicenna Centre for Brain Health Referral

Please ensure your patient has provided consent for this referral

PATIENT INFORMATION		CONTACT PERSON / NOK	
Last Name:		**Last Name:**	
First Name:		**First Name:**	
Phone:		**Phone:**	
DOB (m/d/y):		**Relationship to Patient:**	
Gender: ☐ **M** ☐ **F** ☐ **Other / Unknown**		**Pt PHN:**	
Consent To Consult (Patient or NOK)? ☐ **Y** ☐ **N**		**Extended Health Coverage?** ☐ **Y** ☐ **N**	
Consent to Review Health Authority Records? ☐ **Y** ☐ **N**			

GP/NP INFORMATION

GP/NP:	
Telephone:	**Fax:**

Reason for Referral (Presenting Problems & Expected Outcome):
Medical Conditions & Surgeries:
Current Medications:
Allergies:
Current / Previous Psychiatric History:

Identified risk:	Concern	Identified risk	Concern	Identified Risk:	Concern
Health issues		Recent loss of loved one		Alcohol / substance use	
Cognitive changes		Recent stressful event		Driving concerns	
Aggression (physical / verbal)		Self-neglect		Financial abuse	
Behavioral changes		Mood changes		Physical abuse	
Suspiciousness / paranoia		Suicidal thoughts		Homeless or at risk	
Wandering		Disturbed sleep		Falls / Gait disorder	
Client lives alone		Appetite changes		Freq hospitalizations	
Firearm / Weapons / gun		Caregiver stress		Other	