ST. MICHAEL'S
UNITY HEALTH TORONTO

7 4 6 3 9

Project Dignify Referral Form

PLEASE FAX TO:

St. Michael's Hospital
30 Bond Street, 17 Cardinal Carter South
Toronto, ON M5B 1W8
Phone: 416-864-5120 Fax: 416-864-5007

CATCHMENT FOR SERVICES

- East of Yonge St.
- West of Victoria Park Ave.
- North of Lake Ontario
- South of Bloor St.

REFERRAL SOURCE INFORMATION:		
Name:	Referring Physician OHIP Billing # (required*)	
Address:		Postal Code:
Tel:	Fax:	Email:
Specialty (specify):	Family Physician (if different):	

PATIENT INFORMATION:			
Lives in catchment area (see above) ☐		Patient consents to referral ☐	
Date of Referral:		Requires Interpretation Services Yes ☐ No ☐ Language: _____	
Last Name:	First Name:	MRN (if available):	
Address:			
Postal Code:	Tel:	Mobile:	Gender Pronouns:
DOB (MM/DD/YY):	Health Card Number:		Version Code:
Consent to leave message: Voicemail Yes ☐ No ☐ With another person Yes ☐ No ☐			
Source of Income:		Contact if relevant:	
SDM Information:			

PLEASE CHECK BOXES TO INDICATE WHAT COLLATERAL AND CONSENT FORMS YOU ARE PROVIDING:
*****If Collateral is not include processing may be delayed*****

- ☐ Initial intake consultation note
- ☐ Hospital Discharge summary
- ☐ List of current and past medication/Pharmacy records
- ☐ Completed Assessments
- ☐ Relevant Medical Records
- ☐ Copy of CTO

REASON FOR REFERRAL:

INCLUSION CRITERIA

- Aged 60 years and older
- Homeless, significantly underhoused, or at risk of homelessness
- Presence of a mental disorder
- Mild to Moderate cognitive disorder is **NOT** an exclusion criteria
- Would benefit from outreach services

Problems with functioning in one or more of the following domains:

- substance use
- physical health issues
- daily living activities
- social relationships
- finance
- legal issues

ADDITIONAL INFORMATION:

Current psychiatric diagnosis and presentation including signs and symptoms (please include most recent consultation, discharge summary or notes):

Past Psychiatric diagnosis and treatment, including medication trials:

Date	Medication	Dose	Outcome

Past Medical History (please include relevant reports or attach patient profile summary):

LIST OF ALL KNOWN HOSPITALIZATIONS IN LAST 5 YEARS (Please attach discharge summaries)

Hospital	Admission and Discharge Dates	Reason for Admission

Any problems in the following areas:	PRESENT		PAST		DETAILS
	Y	N	Y	N	
Developmental Disability					
Head Injury					
Cognitive Disorder					
Personality Disorder					
HIV					
Homelessness/Risk ** if experiencing homelessness please include preferred shelters and hangouts					
Substance Use					
Care History (CAS/CCAS)					
Learning Disorder					
Financial Concerns					
Social Relationships					
Activities of Daily Living					
Mobility Issues					
Violent Behaviors					**Please put context in box below
Suicide Attempts					**Please put context in box below
Other self-harm behavior					**Please put context in box below
Legal Involvement					**Please put context in box below

Additional context for violent behaviors, suicide attempts, self-harm and legal involvement

Agencies, Mental Health therapies, Community Supports already involved:

Signature

Date of referral:

Name (print)

Designation