Dr. Akshya Vasudev
MBBS, MD, MRCPsych
Specialist Geriatric Psychiatrist offering consultation
and short-term follow-up of geriatric psychiatry presentations
in London and Middlesex via virtual and in-location assessment
(patient homes, retirement homes and nursing homes)

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REFERRAL FORM

Patient Information

Last Name: _____ Gender: _____
First Name: _____ Age: _____
Preferred Name: _____ DOB: _____
Address: _____ Phone Number: _____
_____ Email: _____
OHIP #: _____ Version Code_____ Interpreter Required? * Y/N
*Please note: If the patient would need interpreter services, we will be invoicing the patient for this service.

Contact Information if different from patient

Primary Contact

Name Email Phone

_____

Secondary Contact

Name Email Phone

_____

Presenting complaint: _____

Does the Referral Meet Any of the Following Criteria for your Geriatric Client? Please put a circle around one of these criteria.

(1) Mood and/or anxiety disorder resistant to trial of at least one antidepressant
(2) Patient is in supported accommodation and displaying behaviour consistent with severe neurocognitive impairment (dementia) and has been already referred to the Behaviour Response Team, LHSC

Please be aware that common reason for decline of referral will be as per following exclusion criteria.

(1) Comorbid substance use disorder
(2) Comorbid personality Disorder
(3) Moderate to severe comorbid medical conditions affecting QOL and functioning
(4) Multiple presentations to acute care/ED
(5) Mild to moderate neurocognitive impairment

If any of these conditions are met, please refer your client to the Geriatric Ambulatory Access Team at St Joseph's Health Care instead available here

GAAT Program

We will endeavor to see this patient within two weeks of your referral. Please be aware that Dr Vasudev is able to offer only short-term consultation and management.

Please send with your referral

- Recent Labs
- Medical Reports
- Medication List
- Copies of memory and mood screening in the last year

Referring Physician/Nurse Practitioner Information

Name: _____
Address: _____
_____Billing Number: _____
Phone: _____Fax: _____
Date of Referral: _____
Signature: _____