# Consent for Psychogeriatric Resource Consultation

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Name of client or SDM if consenting person – please print)**

This consent authorizes the PRC to assess the individual, and to make recommendations to the referral facility/agency regarding care approaches/care planning; this consultation will include a review of the clinical record and discussion with care staff. I further consent to the PRC sharing this assessment information with the relevant circle of care involved with the client, e.g. /not limited to attending physicians, LHIN, BSO, Geriatric Specialist, PSW Agency. I further consent to the storage of this client personal/health information on a secure charting database kept by the Alzheimer Society; I understand that I may contact the Alzheimer Society at any time to revoke this consent to store/share the individual’s personal information.

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Health Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SDM to be contacted prior to visit? Y/ N

SDM name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SDM Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PSW Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name at Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Agency) Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent information above was reviewed with Client/SDM □ (please check) obtained by Name:(print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext \_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Person obtaining verbal consent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE FAX REFERRALS TO THE APPROPRIATE OFFICE:**

**Haldimand and Norfolk (519)** **428-2968**

**Brant (519) 759-8353**

**Hamilton (905) 529-3787**