MEDICAL STABILITY CHECKLIST for referrals to NSM LHIN Inpatient Mental Health

INSTRUCTIONS: Complete **ALL SECTIONS** of this form and send with referral documents to Schedule 1 site

If additional testing is requested, if there is disagreement on significance of findings or if there are ongoing medical issues, it is recommended that the Schedule 1 Physician contact the Emergency Department Physician to resolve concerns.

PATIENT NAME: **DOB:**

HISTORY & MEDICAL EXAM	**Yes**	**No**	**If yes, list details:**
Abnormal Vital Signs Temp >38 °C; Pulse outside of 50 to 120 BPM; RR > 24 breaths/min; BP Systolic <90 or > 200; Diastolic >120	☐	☐	
Allergies	☐	☐	

Circle any conditions present: ☐ HTN ☐ Head Injury ☐ Dementia ☐ CAD ☐ Seizure HX ☐ Substance abuse ☐ DM2

Other:

Required LAB INVESTIGATIONS for all patients	**Abnormal results**		**If Yes, note clinical significance**
	Yes	**No**	
Urine Drug Screen for ALL Waypoint referrals, on request of admitting physician for OSMH & RVH	☐	☐	
CBC	☐	☐	
Glucose	☐	☐	
AST, ALT, ALP, Bili, GGT	☐	☐	
Na, K, Cl, BUN, Creatinine	☐	☐	
TSH	☐	☐	
ß HCG (female patients aged ~ 12-55)	☐	☐	
Blood Alcohol Level **	☐	☐	

**Baseline BAL required, after which BAL can be estimated based on decline of 4-7 mmol/hour
BAL admission criteria: Waypoint BAL= 0 mmol; OSMH BAL <17 mmol; RVH at the discretion of admitting physician

LAB & DIAGNOSTIC TESTING as indicated by history & physical exam

Circle any tests ordered: ☐ Urinalysis ☐ HCO3 in cases of overdose ☐ ECG ☐ CT scan head ☐ Chest X-ray ☐ Other:

TREATMENT	**Yes**	**No**
List of current medications **attached**	☐	☐
List of treatments received in ED **attached**	☐	☐
Results of lab & diagnostic tests **attached**	☐	☐

MEDICATIONS ADMINISTERED in Emergency Department (including dose and time administered)

STATEMENT OF MEDICAL STABILITY

I have examined the patient and determined that their medical condition is sufficiently stable for transfer to a Schedule 1 Psychiatric Inpatient unit.

Completed by: Douglas Chisholm _____ _____ _____

Print Physician Name *Physician Signature* *Date and time*