MEDICAL STABILITY CHECKLIST for referrals to NSM LHIN Inpatient Mental Health

Part A: Historical Features of illness that may prompt a more thorough medical workup prior to transfer

- First presentation of a psychiatric/mental health/psychotic problem? ☐ Yes ☐ No
- New significant abnormal finding on focused physical exam including focused neurological exam or significantly abnormal vital signs? ☐ Yes ☐ No
- New physical complaint(s)? ☐ Yes ☐ No
- New or exacerbation of chronic medical illness needing further evaluation or management? (Including but not limited to seizures, infections, immunosuppression, malignancy) ☐ Yes ☐ No
- Altered level of consciousness or fluctuating mental status (e.g. delirium)? ☐ Yes ☐ No
- Evidence of intoxication or withdrawal or possible recent history of substance abuse? ☐ Yes ☐ No
- New medication or possible overdose or toxidrome from medications? ☐ Yes ☐ No
- Suspicion of pregnancy? ☐ Yes ☐ No

If No to all above questions consider no further investigations and proceed to Part B.

If Yes to any of the above questions, use clinical judgment to consider which if any further investigations are required (circle any ordered and include results in referral):

- Laboratory tests e.g. CBC, Electrolytes, Urea, Creatinine, Blood glucose, LFTs, EtOH, ASA, Acetaminophen, Drug levels, Beta HCG
- Urine toxicology
- ECG
- Diagnostic Imaging
- Other (Specify):

Part B: Additional assessment and details necessary to facilitate safe transfer

- Home medications reviewed and any recommended changes clearly indicated (Med list **and** MAR must be sent with referral) ☐ Yes ☐ No
- Special needs which need to be accommodated in a Mental Health Inpatient Unit? (Including intravenous treatment, feeding tube, stoma, wound care, breast feeding, bariatric needs, etc.) ☐ Yes ☐ No
  Please provide details: ____________________
- History or risk of complicated withdrawal syndrome (ex. Seizures, Delirium tremens, High dose non-prescribed opioids) ☐ Yes ☐ No

Additional Comments

I have assessed and am of the opinion that the patient's medical condition is stable for transfer/admission to a Mental Health Inpatient Unit with limited medical resources and diagnostics.

Completed by: ____________________ ____________________ ____________________ ____________________

Physician Name | Signature | Date | Time

DRAFT