Centralized Intake and Referral Application to Specialty Hospitals

CLIENT INFORMATION **** upon completion of referral please fax to 416-506-0439 ****

Client Name: ___________________________________ **Gender:** ☐ Male ☐ Female ☐ Other ___________

Client Preferred Name: ____________________________ **Weight:** ________________ **Height:** ___________________

D.O.B.: (dd/mm/yy) ______/______/______ **Age**: _____ **Language spoken:** __________________________________

OHIP #: _________________ **Version code:** _________ **Preferred language:** _________________________________

Marital status:_______________________________________

Former patient of a specialty hospital? ☐ Yes ☐ No **If yes, please specify:** _______________________________

Interpreter needed? ☐ Yes ☐ No

HOSPITAL PREFERENCE

Please rank 1, 2, 3 and 4: Baycrest Behavioural Neurology____ Baycrest Psychiatry ____

CAMH ____ Toronto Rehab Institute ____

REASON FOR REFERRAL

Reason for Referral *(please describe presenting behaviours)*:

PRESENTING BEHAVIOURS

Please check all that apply:

- ☐ Verbal aggression
- ☐ Psychotic symptoms
- ☐ Hoarding/rummaging
- ☐ Threatened/Attempted suicide
- ☐ Delusion / Hallucination
- ☐ Memory problems
- ☐ Territorial behaviour
- ☐ Physical aggression
- ☐ Depression
- ☐ Restlessness / Pacing
- ☐ Threat to Self
- ☐ Disruptive Sleep Pattern
- ☐ Unsafe smoking
- ☐ Problem with Addiction/Dependency
- ☐ Inappropriate sexual behaviours
- ☐ Refusal of treatment (e.g. medication)
- ☐ Resistive to care (# of staff req'd to provide care: ___________)
- ☐ Threat to Others
- ☐ Disrobing
- ☐ Exit-seeking
- ☐ Other: ____

For items checked, please provide additional details and describe behaviours:

CURRENT DIAGNOSES

Primary Diagnosis:

Co-morbid Medical Diagnosis:

Secondary Diagnosis:

Mental Health & Addiction issues:

PSYCHIATRIC HISTORY

Does client have a history of mental illness: ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Schizophrenia ☐ Anxiety disorder ☐ Dementia

☐ Substance-related disorder ☐ Personality Disorder (MMSE score: ______________)

☐ Mood Disorder, please indicate: ☐ dysthymic ☐ sad ☐ elated ☐ angry ☐ other: _________

☐ Other: ____

Please describe the client's history of hospitalization (e.g. number of admissions, where admitted, etc…)

SOCIAL, CULTURAL, PSYCHOSOCIAL INFORMATION AND DEVELOPMENTAL HISTORY

Information may include: Place of birth, sexual orientation, children, grandchildren, family background, education, employment, income, family/friend involvement and visitation patterns, leisure time hobbies and interests, religious affiliation, or any history of abuse including elder abuse.

ACTIVITIES OF DAILY LIVING

Dressing:	☐ Independent	☐ Supervision	☐ Total Care (# of staff to provide care: ___________)			
Bathing	☐ Independent	☐ Supervision	☐ Total Care (# of staff to provide care: ___________)			
Feeding	☐ Independent	☐ Supervision	☐ Total Care			
Sleep pattern:	☐ Normal	☐ Disrupted	Explain: ______________________________			
Transfers:	☐ Independent	☐ Supervision	☐ Assistance x 1	☐ Assistance x 2	☐ Assistance x 3	☐ Mechanical Lift
Ambulation:	☐ Independent	☐ Supervision	☐ Assistance x 1	☐ Assistance x 2	☐ Assistance x 3	☐ Non-ambulatory
Speech:	☐ Incoherent	☐ Slurred	☐ Rapid	☐ Slow	☐ Pressured	☐ Others _______________
Continence:	☐ Independent	☐ Supervision	☐ Total Care	☐ Incontinent (# of staff to provide care: ___________)		
Client uses:	☐ Glasses	☐ Hearing Aid	☐ Dentures	☐ Mobility aids		
Mobility needs:	☐ Cane	☐ Walker	☐ Wheelchair	☐ Other ______________________________		
Safety issues:	☐ Falls Risk	☐ Fire setting	☐ Choking / Swallowing Concerns	☐ 1:1 Sitter	☐ Constant Supervision	
	☐ Other ______________________________					

ALLERGIES

Client has known ***medication allergies*** : ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

Other allergies: ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

INFECTIONS/VACCINATIONS

Is the client currently positive for the following diseases? (*check all that apply*):

☐ MRSA ☐ C-difficile ☐ VRE ☐ TB ☐ ESBL

Isolation /precautions (check all that apply): ☐ Standard ☐ Contact ☐ Droplet ☐ Airborne ☐ Other ________________

Has the client received a flu shot? ☐ Yes ☐ No

If yes, specify date of last flu shot received: ____

CURRENT MEDICATIONS

MAR included with application: ☐ Yes ☐ No *If "no" please complete medication list*

Name	Dose	Frequency	Last Taken	Pharmacy Info	Source of Info.

If you require more space, please attach a sheet with additional medication information

CONTACT/SUBSTITUTE DECISION MAKER (SDM) / POWER OF ATTORNEY (POA)

Treatment decisions made by: ☐ Self ☐ Power of Attorney (POA) ☐ Public Guardian/Trustee (PGT) ☐ Substitute Decision Maker (SDM)

Contact name: ______________________ **Relationship: (Spouse, Child, POA, PGT):** ____________

Address: ____

Home phone # : ____________ Work # : ______________ Mobile #: ____________

Financial decisions made by: ☐ Self ☐ Power of Attorney (POA) ☐ Public Guardian/Trustee (PGT) ☐ Substitute Decision Maker (SDM)

Name: ____

Address: ____

Home phone # : ____________ Work # : ______________ Mobile #: ____________

OTHER RELEVANT INFORMATION

Current Living Arrangements: ☐ lives alone ☐ with parents ☐ with partner / spouse ☐ with children

☐ LTCH ☐ with others (specify): ________________

Address & Phone #: ____

Is the client developmentally delayed? ☐ Yes ☐ No

Any diagnosis of being developmentally delayed? ☐ Yes ☐ No

Is the client medically stable? ☐ Yes ☐ No

Specify:

Does patient have a DNR order? ☐ Yes ☐ No

Specify:

Any Advance Directives? ☐ Yes ☐ No

Specify:

List any outstanding medical appointments of the client:

Other Medical Needs:

IV Therapy ☐ Yes ☐ No **Oxygen** ☐ Yes ☐ No **Colostomy** ☐ Yes ☐ No

Catheter ☐ Yes ☐ No **Wound Care** ☐ Yes ☐ No **Tube-feeding** ☐ Yes ☐ No

REFERRAL SOURCE INFORMATION

Referral Source:

☐ Hospital ☐ LTCH ☐ Community ☐ Self/Family ☐ LHIN (specify): ______________________

☐ MD Name of MD: ______________________ Phone # ____________________

Name of Facility: ____

Facility Address: ____

Date of Admission to organization (dd/mm/yy) _______/________/________

Facility Contact Name: ____ Professional Designation: ____________________

Telephone #: ____________________ Fax #: ________________ **Email:** ____________________________________

Name of Family Physician: ____________________________

Address: ____

Telephone #: ____

Fax #: ____

Name of Specialist: ____________________________________

Type of Specialty: __________________________________

Telephone #: _______________________________________

Fax #: ____

Has the client been seen by: ****** PLEASE INCLUDE NOTES ******

Geriatric Mental Health Outreach Team (G-MHOT): ☐ Yes ☐ No and/or

Mobile Outreach Team: ☐ Yes ☐ No and/or

Psychogeriatric Resource Consultant (PRC): ☐ Yes ☐ No and/or

Other: ____

ADMISSION GOALS / EXPECTED OUTCOMES

Please be specific and realistic as possible (e.g. stabilize medication use, enable return to LTCH, and enhance functioning of person)

DISCHARGE PLANS

What is the expected discharge destination for this client after completion of his/her stay? *(please check)*

☐ Return Home ☐ Return to referring Facility ☐ Placement in LTCH ☐ Other: ______________________________

CHECKLIST

****** upon completion of referral please fax to 416-506-0439 ******

Items that must be included with application:

☐ Lab results, consults, etc. in past 3 months
☐ Current medication use or MAR
☐ Take-back letter (signed by appropriate individual/organization)
☐ Advance Directives
☐ Next of kin/ POA /Substitute Decision Maker documentation
☐ Psychiatric Consultation/Geriatric Mental Health Outreach Team Notes

SIGNATURES

Referral information completed by: ____________________________ **Phone #:** ____________________________

Signature: ____ **Date:** ____________________________

Referring Physician: ____________________________________ **OHIP Billing:** ____________________________

Signature: ____ **Date:** ____________________________

Phone #: ____

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Consent
(All referrals)

The client, SDM or POA has been informed, understands and is in agreement with this referral.

______________________________	______________________________
Name of client, POA or SDM	Signature
______________________________	______________________________
Telephone #	Date

Take Back Agreement
(Applicable to referrals from Hospital or LTC clients only)

This letter serves as our understanding and agreement that

____________________________________ will be accepted back into
(Client name)

____ upon discharge from (please circle)
(Referring facility name)

Baycrest Behavioural Neurology   Baycrest Psychiatry

CAMH   Toronto Rehab Institute

____ ______________
(Name of Director of Care/Administrator of Referring Facility)   Title

______________________________	______________________________
Telephone #	Fax #
______________________________	______________________________
Signature	Date