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	□ Territorial behaviour	□ Problem with Addiction/Dependency
□ Psychotic symptoms	□ Physical aggression	□ Inappropriate sexual behaviours
□ Hoarding/rummaging	□ Depression	□ Refusal of treatment (e.g. medication)
□ Threatened/Attempted suicide	□ Restlessness / Pacing	□ Resistive to care (# of staff req'd to provide care: _____)
□ Delusion / Hallucination	□ Threat to Self	□ Threat to Others
□ Memory problems	□ Disruptive Sleep Pattern	□ Disrobing
	□ Unsafe smoking	□ 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 Any Advance Directives? ☐ Yes ☐ No

Specify: 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: _____	*Name of Specialist:* _____
Address: _____	Type of Specialty: _____
Telephone #: _____	Telephone #: _____
Fax #: _____	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

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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