Toronto Central **LHIN**

Referral Form for Baycrest Long-Term Care Behavioural Support Outreach Team

Fax Referral to 647-788-4883

Referral Date (dd/mm/yyyy): Click here to enter a date.

LTC-BSOT Client information

Name (last, first): Click here to enter text. **Sex:** ☐ **M** ☐**F** **D.O.B** (dd/mm/yyyy): Click here to enter a date. **Age:**_____

Health Card #: Click here to enter text. **VC:** _____ Language: Click here to enter text. Culture: Click here to enter text.

Name of SDM/POA: Click here to enter text. **Relationship:** Click here to enter text. **Contact Phone#:** Click here to enter text.

Name of LTC: Click here to enter text. **Unit:** Click here to enter text.

Family physician: Click here to enter text. **Billing #:** Click here to enter text.

Referral Information

Is this a re-referral?: ☐ **Yes** ☐ **No** **Admission date to LTC facility** (dd/mm/yyyy): Click here to enter a date.

Referral Source Name/Contact: Click here to enter text. **Phone #:** Click here to enter text. **Fax#:** Click here to enter text.

Dementia diagnosis (Alzheimer's, FTD, Vascular, Mixed, Unspecified, Lewy Body, Korsakoff, other): ☐ **Yes** ☐ **No**

Additional medical diagnosis: Click here to enter text.

Psychiatric History: Click here to enter text.

Immediate concern for referral: Click here to enter text.

Behavioural issues identified related to concern for referral (please check off the relevant issues):

☐Repeating sentences/questions
☐Shouting, threatening, cursing others
☐Destroying property
☐Hitting, kicking, spitting, punching, scratching, biting others
☐Rude, critical, insulting, complaining
☐Unwanted sexual touching/inviting
☐Wandering, aimless pacing
☐Hitting, scratching, injuring self
☐Calling out, crying
☐Disrobing, exposing self
☐Fidgeting, picking, repeating action
☐Refusing/resistive to care; bathing, changing
☐Other: Click here to enter text.

Please identify your goal for this referral: Click here to enter text.

Please provide any other relevant information you would like to share regarding this referral: Click here to enter text.

Baycrest

Ontario
Toronto Central Local Health Integration Network

Please attach most recent Medication Administration Record as well as a one (1) week of Dementia Observational System (DOS) chart.