Virtual Behavioural Medicine Consultation Program

A collaborative partnership between the Baycrest
Sam & Ida Ross Memory Clinic and Behavioural Support Outreach Programs
Fax Referral to 647-788-4883 or Email to behavioursupport@baycrest.org

Referral Date (dd/mm/yyyy):_____

Client Information

Name (last, first): _____ **Sex:** ☐ **Male** ☐**Female** ☐**Transgender** ☐**Prefer not to identify**
D.O.B (dd/mm/yyyy): _____**Health Card #:**_____**VC:** _____ **Language:**_____
Name of SDM/POA:_____**Relationship:** _____ **Phone #:**_____
Email:_____
Current Client Location and Address: _____ **Unit:** _____
Primary Contact Person (who will be present and accompany client in the virtual appt. to provide medical history/background, can be a staff or family member): _____
Phone #: _____**Email:**_____
Family physician:_____**Billing #:**_____
Patient/SDM consents to being referred to the Virtual Behavioural Medical Consultation Program and other related programs that the care team identifies may be beneficial to their care ☐ **Yes** ☐ **No**

Referral Information

Referring Organization: _____ **Organization Fax#:** _____
Referring MD/NP: _____ **Billing #:**_____
Primary Contact: _____ **Phone #:** _____
Fax#: _____ **Email:** _____
Location to send prescriptions: _____ **Fax#:** _____

Client Medical Information

Immediate reason for referral: _____
Dementia diagnosis ☐ **Yes** ☐ **No** **Please circle:** Alzheimer's, FTD, Vascular, Mixed, Lewy Body, Korsakoff, other:
Psychiatric History (if applicable): _____
Additional medical diagnoses: _____
Behavioural issues identified related to reason 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 attach any recent blood work (within the last 6 months), if available:

- CBC, Electrolytes, Hemoglobin A1C, Vitamin B12, Calcium, AST/ALP/ALT, TSH, GGT, Creatinine & eGFR

Please attach medical information below, if available:

- List of current medications
- Results of prior brain CT, MRI, or SPECT
- Prior neurology, psychiatry, or psychology reports
- Any recent behaviour team reports

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