Baycrest Inpatient Psychiatry Unit Referral

Referral Date (dd/mm/yyyy): _____

Client Information

Name (last, first): _____ **Preferred Name:** _____ **DOB (dd/mm/yyyy):** _____ **Age**: ___
Gender: _____ **Weight**: _____ **Height**: _____ **Health Card #:** _____ **VC**: _____ **HCN Expiry**: _____
Client Phone Number: _____ **Client Email:** _____
Languages spoken: _____ **Interpretation Required:** ☐ Yes ☐ No **Marital Status:** _____
Current Location: ☐ Community - Lives Alone ☐ Community - With Family ☐ Retirement Home ☐ Long Term Care ☐ Hospital ☐ Other: _____
Location Name/Address: _____ **Unit:** _____
Postal Code: _____ **Admission Date to Current Location** (d/m/y): _____ **ALC?:** ☐ Yes **ALC Start Date**: _____

Contact Information/Substitute Decision Maker (SDM)/Power of Attorney (POA)

Treatment Decisions made by: ☐ POA/SDM(s) (*if multiple, list all)* ☐ Ontario Public Guardian & Trustee (PG&T) ☐ Other: _____
Contact Name(s): _____
Relationship (Spouse, Child, POA, PGT): _____ **Lives with client?:** ☐ Yes ☐ No
Phone Number: _____ **Email:** _____
Financial Decisions made by: ☐ Same as above
☐ POA/SDM(s) (*if multiple, list all)* ☐ Ontario Public Guardian & Trustee (PG&T) ☐ Other: _____
Contact Name(s): _____
Relationship (Spouse, Child, POA, PGT): _____ **Lives with client?:** ☐ Yes ☐ No
Phone Number: _____ **Email:** _____

Referral & Medical Information

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

Presenting Behaviours Related to Reason for Referral: (select all that apply)

☐ **Psychotic symptoms**
☐ **Depression**
☐ **Suicidal behaviour** (threats and/or attempts)
☐ **Delusions/Hallucinations**
☐ **Hoarding/rummaging**
☐ **Memory Problems**
☐ **Territorial Behaviour**
☐ **Verbal aggression**
☐ **Threat to self**
☐ **Threat to others**
☐ **Unsafe smoking**
☐ **Problem with Addiction/Dependency**
☐ **Disruptive Sleep Pattern**
☐ **Refusal of treatment (e.g. medication)**
☐ **Anxious behaviour**

☐ Other (*please specify*): _____
For items checked, please provide additional details: _____

Current Diagnoses

Primary Diagnosis: _____
Secondary Diagnosis: _____
Co-morbid Medical Diagnoses: _____
Psychiatric/developmental diagnoses/history: _____

Medical Information & Hospital History

Former patient of a specialty behavioural unit at a hospital? ☐ Yes ☐ No If yes, specify: _____
History of psychiatric admissions? ☐ Yes ☐ No
Briefly describe history of hospitalizations (e.g. number of admissions, where admitted, etc.): _____

Is the client medically stable? ☐ Yes ☐ No
Code Status: _____ **Advance Directives?** ☐ Yes ☐ No
If yes, specify: _____

Allergies: ☐ Known Medication Allergies ☐ Other Allergies
Please list:

Up to date on COVID & flu vaccinations? ☐ Yes ☐ No

Please Fax to to 647-788-4883 or Email to behaviouralsupport@baycrest.org. For Program Inquiries, call 416 785 2500 x2005

Baycrest Inpatient Psychiatry Unit Referral *(continued)*

Medical Information & Hospital History *(continued)*

Medical Needs (if checked, specify in Additional Medical Information):
☐ IV Therapy ☐ Catheter ☐ Oxygen ☐ Wound Care ☐ Ostomy
☐ Tube-feeding
Infections: Currently positive for the following?: ☐ MRSA ☐ C-difficile
☐ VRE ☐ TB ☐ ESBL
Isolation/precautions: ☐ Standard ☐Contact ☐Droplet ☐Airborne

Additional Medical Information:

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 x1	☐ Assistance x2	☐ Assistance x3	☐ Mechanical Lift
Ambulation:	☐ Independent	☐ Supervision	☐ Assistance x1	☐ Assistance x2	☐ Assistance x3	☐ Non-ambulatory
Speech:	☐ Incoherent	☐ Slurred	☐ Rapid	☐ Slow	☐ Pressured	☐ Other:
Continence:	☐ Independent	☐ Supervision	☐ Total Care	☐ Incontinent (# of staff to provide care: _____)		
Mobility:	☐ Cane	☐ Walker	☐ Wheelchair	☐ Other:		
Safety Issues:	☐ Fall Risk	☐ Fire Setting	☐ 1:1 Sitter	☐Choking / Swallowing Concerns	☐ Constant Supervision	
Aids:	☐ Glasses	☐ Hearing Aids	☐ Dentures	☐ Mobility Aids		

Social, Cultural & Psychosocial Information

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.

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/Disposition

What is the expected discharge destination for this client after completion of their stay?
☐ Return Home ☐ Return to referring facility ☐ Placement in Long-Term Care Home ☐ Other: _____

Referral Source Information

Referral Source: ☐ Hospital ☐ LTC ☐ Community ☐ Self/Family ☐ MD Name of MD: _____ Phone: _____

Referral/Facility Contact Name: _____ **Role**: _____
Name of Facility: _____
Facility Address: _____
Phone Number: _____ Fax: _____ Email: _____

Name of Family Physician: _____
Address: _____
Phone: _____ Fax: _____

Name of Specialist: _____
Type of Specialty (e.g. psychiatry): _____
Phone: _____ Fax: _____

Signatures (REQUIRED)

Referring Provider (MD/NP): _____ **OHIP Billing:** _____
Phone: _____ **Fax:** _____ **Address:** _____

Signature: _____ **Date:** _____

Please attach the following information below:

☐Current medication list and/or Medication Administration Record (MAR)
☐Psychiatry/Geriatric Mental Health Outreach Team consultation notes
☐Most recent lab results (bloodwork, urine, etc.) – *past 3 months preferred*
☐All relevant consultation reports/notes with health/psychiatric history
☐Next of kin/POA/SDM documentation
☐Advanced Directives

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CONSENT & TAKE BACK AGREEMENT

Client / Power of Attorney (POA) / Substitute Decision Maker (SDM) Consent

The client and/or SDM/POA have been informed, understand and agrees with referral for consideration for admission to the Baycrest Inpatient Psychiatry Unit.

_____ _____

Name of client or POA/SDM *Phone Number*

_____ _____

Signature *Date*

Facility Take Back Agreement

(Applicable to referrals from Hospitals or Long Term Care Homes only)

This letter serves as our understanding and agreement that:

_____ will be accepted back into

Client name

_____ upon discharge from:

Facility Name

Baycrest's Inpatient Psychiatry Unit

_____ _____

Name of Director of Care/Administrator of Referring Facility *Title/Position*

_____ _____

Phone Number *Fax Number*

_____ _____

Signature *Date*