Ontario Health atHome

Centralized Intake and Referral Application to Specialty Hospitals

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

Patient Name: _____ **Gender:** ☐ Male ☐ Female ☐ Other _____

Patient 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 Patient 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: _____)

Patient 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

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

If yes, please specify:

Other allergies: ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

INFECTIONS/VACCINATIONS

Is the Patient 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 Patient 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 Patient developmentally delayed? ☐ Yes ☐ No Any diagnosis of being developmentally delayed? ☐ Yes ☐ No

Is the Patient medically stable? Specify: ☐ Yes ☐ No

Does patient have a DNR order? ☐ Yes ☐ No Any Advance Directives? ☐ Yes ☐ No

Specify: Specify:

List any outstanding medical appointments of the Patient:

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

_____ _____

Name of Patient, 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
(Patient 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