Virtual Behavioural Medicine Consultation Program (VBM) & Centralized Access to Seniors Specialty Hospital Beds (CASS)

Referral Checklist

PART 1:

For Virtual Behavioural Medicine Consultation Program only:

☐ Complete ***Virtual Behavioural Medicine Program referral form***

Be sure to:

- Fill out ***ALL FIELDS*** including Client Information, SDM/POA information, Primary Contact information, Referral & Medical Information, Behaviours checklist, BSO contacts
- Include physician/NP/MRP name, billing number & signature

☐ Attach following documents (if available):

- ☐ Current medication list and/or MAR
- ☐ Neurology/psychiatry consultation notes
- ☐ Most recent medical reports and lab results (bloodwork, urine, etc.)
- ☐ Behaviour Supports Notes (BSOT, BSS, internal BSO Lead)
- ☐ Nursing/progress notes related to behaviours
- ☐ POA/SDM documentation
- ☐ Cognitive assessments
- ☐ BSO-DOS, assessments, care plans

PART 2:

For Centralized Access to Seniors Specialty Hospital Beds (CASS) application:

☐ Complete all above for ***VBM Referral*** + attach **required documents** (same as above PLUS: Vaccination Record, Advanced Care Directives, Diet Orders)

☐ Complete ***CASS Supplemental Information Form***

☐ Complete ***CASS Consent & Take Back Agreement***

Failure to provide the above completed information may result in delays in referral processing or acceptance.

Referrals & Documents to be Faxed to 647-788-4883 or Emailed to behaviouralsupport@baycrest.org

For Program Inquiries, call the Toronto Region BSO Coordinating Office at **416-785-2500 x2005** or email **behaviouralsupport@baycrest.org**

Virtual Behavioural Medicine Consultation Program

A collaborative partnership between the Baycrest Sam & Ida Ross Memory Clinic, Behavioural Support for Seniors Program at Baycrest Health Sciences & Toronto Rehabilitation Institute

In partnership with: UHN (Toronto General, Toronto Western, Princess Margaret, Toronto Rehab, Michener Institute)

Referral Date (dd/mm/yyyy): _____ **Client Preference:** ☐ Baycrest VBM ☐ Toronto Rehab VBM ☐ *No preference/next available*

Client Information

Name (last, first): _____ **Preferred Name:** _____ **DOB (dd/mm/yyyy):** _____ **Age**: ___
Gender: _____ **Weight**: _____ **Height**: _____ **Health Card #:** _____ **VC**: _____ **HCN Expiry**: _____
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:** _____ **Unit phone number:** _____
Postal Code: _____ **Admission Date to Current Location** (d/m/y): _____ **ALC?:** ☐ Yes **ALC Start Date**: _____

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

Does the SDM/POA consent to being referred to VBM and other related programs identified as beneficial to their care? ☐ **Yes** ☐ **No**

Treatment decisions made by: ☐ POA ☐ SDM ☐ Ontario Public Guardian & Trustee (PG&T) ☐ Other: _____
SDM/POA Name(s) *(if multiple, please enter all)*: _____
Relationship to client: _____ **Phone Number(s):** _____
Email(s): _____ **Lives with client?:** ☐ Yes ☐ No

Primary Contact Information (for facilitating VBM appointments and information gathering) **please fill out if different from above*
Name: _____ **Role:** _____ **Organization:** _____
Phone #: _____ **Fax#:** _____ **Email:** _____

Referral & Medical Information

Reason for referral: _____
Dementia dx known: ☐ **Yes** ☐ **No** **If yes:** ☐ Alzheimer's Disease ☐ FTD ☐ Vascular ☐ Lewy Body ☐ Mixed ☐ Korsakoff ☐ Other: _____
Psychiatric History (if applicable): _____
Currently active with psychiatry? ☐ **Yes** ☐ **No** **If yes, has psychiatry been notified of VBM referral?** ☐ **Yes** ☐ **No**
***If applicable*: Psychiatrist's Name:** _____
Clinic/Team Name/Address/Facility (i.e. GMHOT): _____
Phone: _____ **Fax:** _____ **Email:** _____
Additional medical diagnoses: _____ Is the client medically stable?: ☐ Yes ☐ No

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

- ☐ **Wandering/Exit-seeking**
- ☐ **Physically Responsive Behaviour** (spitting, kicking, grabbing, pushing, scratching, biting etc.)
- ☐ **Sexual Behaviour** (unwanted verbal/physical sexual advances toward others, disrobing/exposing self)
- ☐ **Suicidal Behaviour** (threats and/or attempts)
- ☐ **Resistive to Care**
- ☐ **Refusal of Treatment or Medication**
- ☐ **Agitated Behaviour** (restless, anxiety, inability to settle)
- ☐ Other (*please specify*): _____
- ☐ **Destroying property**
- ☐ **Verbally responsive and/or territorial Behaviour** (yelling/screaming, threatening, cursing etc.)
- ☐ **Issues with Addictions/Dependency**
- ☐ **Delusions** (fixed, false beliefs)
- ☐ **Hallucinations** (visual, auditory, gustatory, tactile, olfactory)
- ☐ **Inappropriate Voiding/Defecation**
- ☐ **Disruptive Sleep Pattern**
- ☐ **Fidgeting/Picking/Repetitive Behaviour**
- ☐ **Calling out, crying**
- ☐ **Hoarding** (collecting objects, refusing to remove)
- ☐ **Oral Intake of Non-edible Items/Substances**
- ☐ **Low Mood/Depressed** (crying, tearfulness, apathy, loss of interest/pleasure)
- ☐ **Rummaging** (touching/handling objects with no obvious purpose)

Behaviour Supports (BS) Services

BS Involved: ☐ **Yes** ☐ **No** **If yes, please select:** ☐ **Internal BS Services** ☐ **External BS Services**
BS Clinician Name: _____ **BS Service Organization:** _____
Phone #: _____ **Email:** _____

All VBM referrals require a Billing Number & Signature [Please select one Most Responsible Provider (MRP)]
Referring MD/NP/MRP: _____ **Billing #:** _____ **MD/NP Signature:** _____ ☐ **MRP**
Phone: _____ **Fax:** _____ **Address/Location Name:** _____
Primary Care Provider (PCP)/Family Doctor (if diff. from above): _____ **Billing #:** _____ ☐ **MRP**
Phone: _____ **Fax:** _____ **Clinic Location/Address:** _____

Please attach the following information below:

- ☐ Current medication list and/or Medication Administration Record (MAR)
- ☐ Neurology/psychiatry consultation notes
- ☐ Most recent lab results (bloodwork, urine, etc.)
- ☐ Behaviour Supports Notes (BSOT, BSS, internal BSO Lead)
- ☐ Nursing/progress notes related to behaviours (most recent 2 weeks preferred)
- ☐ Next of kin/POA/SDM documentation
- ☐ Cognitive assessments
- ☐ BSO-DOS, assessments, care plans (if available)

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

If applying to Specialty Hospital Inpatient Unit, please complete Supplemental Form & include it with VBM referral

Centralized Access to Seniors Specialty Hospital Beds (CASS)

Supplemental Information Form

**** ONLY COMPLETE THIS FORM IF APPLYING TO INPATIENT UNIT & SUBMIT WITH COMPLETED VBM REFERRAL****

Patient Name: _____ **Date of Birth (dd/mm/yyyy):** _____

Hospital Preference (Please rank): __Baycrest Behavioural Neurology __Toronto Rehab's Specialized Dementia Unit __CAMH Geriatric Admission Unit

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)

Medical Information & Hospital History

Former patient of a specialty behavioural unit at a hospital? ☐ Yes ☐ No If yes, specify: _____

Psychiatric/developmental diagnoses/history: _____

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: _____

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

Allergies: ☐ Known Medication Allergies ☐ Other Allergies

Please list: _____

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

Additional Medical Information:

Activities of Daily Living

Dressing:	☐ Independent	☐ Supervision	☐ Assisted	☐ Total care	(# of staff to provide care: _____)
Bathing:	☐ Independent	☐ Supervision	☐ Assisted	☐ Total care	(# of staff to provide care: _____)
Feeding:	☐ Independent	☐ Supervision	☐ Assisted	☐ Total care	(# of staff to provide 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	☐ Other: _____

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.

Financial decisions made by: ☐ **Self** ☐ **Power of Attorney (POA)** ☐ **Substitute Decision Maker (SDM)** ☐ **Public Guardian & Trustee (PG&T)**

POA/SDM/PG&T Contact Name: _____ Phone: _____

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: _____

All additional documents specified in VBM Referral are required for CASS consideration. Please include all specified documents with application.

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Baycrest camh Centre for Addiction and Mental Health UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

Toronto Central Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario du Centre-Toronto

Ontario Toronto Central Local Health Integration Network

Centralized Access to Seniors Specialty Hospital Beds (CASS)

Supplemental Information Form

**** ONLY COMPLETE THIS FORM IF APPLYING TO INPATIENT UNIT & SUBMIT WITH COMPLETED VBM REFERRAL****

CONSENT & TAKE BACK AGREEMENT

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 Centralized Access to Seniors Specialty Beds (CASS).

_____ _____

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

Please select:

☐ Baycrest Behavioural Neurology ☐ Baycrest Psychiatry

☐ Toronto Rehab Institute ☐ CAMH

_____ _____

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

_____ _____

Phone Number *Fax Number*

_____ _____

Signature *Date*