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