St. Joseph's Healthcare Hamilton

SENIORS MENTAL HEALTH BEHAVIOURAL INPATIENT REFERRAL FORM

Who do we serve:
We are a 24-bed inpatient Tertiary Program that serves the Region of Hamilton, Niagara, Haldimand, and Brant (HNHB). Our population of focus are older adults with a behavioral disturbance that are associated with a primary diagnosis of Major Neurocognitive Disorder (MND).

When to refer: *Seniors Mental Health Behavioral Unit (SMHBU)is the most intensive care program serving this population in the region of HNHB. Referrals are made to this program when community-based resources have been exhausted and intensive supports are needed to stabilize behaviors related to NCD.*

What our program does: *SMHBU offers specialized and intensive behavioral care resources to manage risk for high intensity and or high frequency behaviors. Our team includes Geriatric Psychiatrists and a multidisciplinary team of health care professionals who specialize in care and treatment of persons with behavioral and psychological symptoms of dementia (BPSD). Our team offer comprehensive assessments and personalized behavioral plans of care that include pharmacological treatment, behavioral approaches/strategies and management/mitigation strategies for risk behaviors.*

Program Goals:
The admission goals are to assess, treat and manage conditions that are driving behaviours and establish a plan of care to manage behavioral disturbances that are associated to a diagnosed neurocognitive disorder and ultimately return to community or care facility that can support the person's needs.

PLEASE FAX ALL REFERRALS TO:

905-381-5620

PLEASE DIRECT ALL TELEPHONE INQUIRES TO:

905-522-1155 EXT. 36208

THE FOLLOWING MUST BE ATTACHED WITH REFERRAL FORM:

- ❒ **Medication Profile (MARS)**
- ❒ **Consultation/Specialists Reports**
- ❒ **Cohen Mansfield Agitation Inventory (CMAI)**
- ❒ **Mini Mental Status Examination**
- ❒ **Clock Drawing Assessment (if available)**
- ❒ **BSO Consult & Care Plan**

.

PATIENT'S INFORMATION

Last Name:	First Name:			❒ Male ❒ Female
Address:	Apt.	City	Prov.	Postal Code:
Home Telephone:	Present Location:			Date Admitted (yyyy/mm/dd):
Date of Birth (yyyy/mm/dd):	Age:	Martial Status: ❒ Single ❒ Married/Partner ❒ Divorced ❒ Separated ❒ Widowed		
Preferred Language:	Other Languages:			Religion:

DIAGNOSIS

Family Physician:	Phone:	Fax:
Consulting Physician:	Phone:	Fax:

HEALTH INSURANCE INFORMATION

Is patient covered under Ontario Health Insurance Plan? ❒ Yes ❒ No If NO, indicate other Health Insurance Plan:	Health Card Number	Version Code:

CONTACT INFORMATION

Next of Kin: Relationship:		Power of Attorney: ❒ Personal Care ❒ Financial
Address:	City: Province: Postal Code:	
Telephone (Home):	Telephone (Work): Ext:	
Primary Contact: Relationship:	Power of Attorney: ❒ Personal Care ❒ Financial	
Address:	City: Province: Postal Code:	
Telephone (Home):	Telephone (Work): Ext.	

CLINICAL ALERTS

Allergies:	❒ No
Diabetic:	❒ No

Current Infections: MRSA: ❒ Yes ❒ No VRE: ❒ Yes ❒ No Other:___

ESBL: ❒ Yes ❒ No

Flu Shot: ❒ Yes ❒ No Date of Last Flu Shot:

.

PATIENT'S INFORMATION

Referral Site	Date:		
Primary Contact:	Phone:	Ext:	Pager:
Primary Contact E-mail:			
Alternate Contact:	Phone:	Ext:	Pager:

MEDICAL CARE HISTORY

Describe history of hospitalization, i.e. number of admissions, where the patient has been admitted

ACTIVE MEDICAL SUPPORT NEEDS

Is the patient medically stable? ☐Yes ☐ No

Does the patient require IV treatment? ☐Yes ☐No

Catheter in place? ☐Yes ☐No

Continuous Oxygen ☐Yes ☐No

Does the patient have a PICC line or other medical device that requires nursing interventions? ☐Yes ☐NO

Has Delirium been ruled out? ☐Yes ☐No If so, when?

MEDICAL HISTORY INCLUDING SPECIALISTS CONSULTS (attach info as needed)

PSYCHIATRIC HISTORY (include hospitalizations):

Does the patient have a history of mental illness? ☐ Yes ☐ No

If yes, please specify:_____

☐ Major Neurocognitive Disorder (Type):

Geriatric/Geriatric Psychiatry Team Involved:	❒ Yes	❒ No	Name:
BSO Team involved:	❒ Yes	❒ No	
PRC (Psychogeriatric Resource Consultant)::	❒ Yes	❒ No	Name:
High Intensity Funding Utilized:	❒ Yes	❒ No	

PRESENT MEDICATIONS (please attach medication profile – MARS)

.

BEHAVIOURAL ISSUES		
Physically responsive Behaviors	**Verbally Responsive Behaviors**	**Others:**
☐ Hitting	☐ Expressive vocalizations (i.e yelling, screaming, arguing)	☐ Visual/ perceptual disturbance/ hallucinations
☐ Kicking	☐ Swearing	☐ Paranoid ideation
☐ Pushing	☐ Repetitive requests	☐ Delusional thinking
☐ Scratching	☐ Verbal refusal of care	☐ Disinhibited behaviours (verbal or physical)
☐ Grabbing	☐ Incontinence inappropriate/public	☐ Sexualized behaviours
☐ Exit-seeking	☐ Disrobing	
☐ Restlessness/pacing		
☐ Collecting items		

LIST BSO & BEHAVIOUAL CARE PLANS

RESPONSIVE BEHAVIOURS

For all responsive behaviours checked above, *please provide additional details and describe the behaviours*.

☐ **Code whites**, *(if yes, explain and provide dates)* :

☐ **Significant Behavioural Events** (*if yes, explain i.e. Need to Increase Resources to manage risk behaviours*) :

☐ **Restraint use** *(If yes, explain and provide dates; i.e. Wheelchair; tamper proof wheelchair; soft restraints, Pinels, Locked Unit; Chemical Restraints)* :

☐ **Dates & Types of Restraints Used**:

How many staff are required for personal care?

.

COGNITIVE ASSESSMENT

Orientation: Person:_____Place:_____Time:_____

Memory:

Language, Spatial Orientation & Coordination:

THINKING

❒ Logical ❒ Disorganized ❒ Coherent ❒ Incoherent

Other: (describe)

HALLUCINATIONS: ❒ Yes ❒ No

❒ Auditory ❒ Visual ❒ Olfactory ❒ Tactile ❒ Taste

Describe, including the effect on client:

DELUSIONS: ❒ Yes ❒ No

FUNCTIONAL ASSESSMENT (complete table below)

Bathing	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Dressing	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Feeding	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Swallowing	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Communication/Aphasia	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Transfers	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Walking	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Wheelchair Mobility	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Bladder Continence	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT
Bowel Continence	❒ INDEPENDENT	❒ SUPERVISION	❒ DEPENDENT

Ostomy: ❒ Yes ❒ No

Mobility Aids: ❒ Cane ❒ Walker ❒ Wheelchair: Owned by Patient ❒ Yes ❒ No ❒ Manual or ❒ Power

Weight Bearing Status: ❒ Full ❒ Partial ❒ Non-Weight Bearing ❒ Mechanical Lift

Movement Restrictions/Precautions – List:

NUTRITIONAL ASSESSMENT

Weight (kgs): Height: Recent weight gain/loss:

Diet:

Diet Texture:

.

FALLS ASSESSMENT

Falls risk identified due to (check all that apply):

❒ Ambulation
❒ Behaviour
❒ Cognitive/perceptual deficits
❒ Climbing out of wheelchair
❒ Climbing out of bed
❒ Unsteady Gait

Date of last fall & description:

COMMUNICATION

Hearing Aid(s): ❒ Yes ❒ No
Eye Wear: ❒ Yes ❒ No

Language spoken: Interpreter needed: ❒ Yes ❒ No
Communication Problems:

SKIN ASSESSMENT

Clear & Intact (present) ❒ Yes ❒ No
Past history of skin breakdown: ❒ Yes ❒ No

Location and description of past or present skin breakdown:

REASON FOR ADMISSION TO CURRENT FACILITY:

GOALS FOR ADMISSION TO SENIORS BEHAVIORAL MENTAL HEALTH PROGRAM:

.

Consent for Referral to Seniors Mental Health Behavioural Unit

The patient, SDM, or POA has been informed, understands, and is agreement with this referral. The decision maker understands this is a hospitalization for the purpose of treatment and stabilization of behaviors with the understanding the person will be discharged back to community. It is imperative that the decision maker is willing to consent to treatment with psychotropic medications in conjunction with other non-pharmacological strategies and are aware the patient will be admitted involuntarily under the Mental Health Act and as such may be detained until ready for discharge.

_____	_____
Name of Patient, SDM, POA	Signature *(Note if Verbal Consent)*
_____	_____
Telephone Number	Date of agreement

.

Repatriation Agreement

**This is applicable to referrals from Hospital, Retirement Homes or Long-Term Care Homes*

_____ will be accepted back _____
(Patient Name) (Referring Facility Name)

Upon discharge from Seniors Mental Health Behavioural Unit.

_____ _____
Name of Manager/ Director of Care of Referring Facility Title

_____ _____
Telephone number Fax number

_____ _____
Signature Date