St. Joseph's Healthcare Hamilton | Seniors Mental Health Outreach Services

Long Term Care Homes
-Niagara Region-
Fax: 905-704-4072

Case #: _____ (Internal Use Only)

Please ensure the following information is included with your faxed referral:

- ☐ Complete resident demographics including contact information for family/SDM contact
- ☐ Valid health card number
- ☐ Copy of blood work/any labs recent within 2-3 months
- ☐ Current medication - MAR
- ☐ Behavioural charting - copy of DOS charting of at least 5 days
- ☐ Signature of Attending Physician
- ☐ Signature of Director of Care or designate
- ☐ Relevant investigations (e.g. head CT/MRI, ECG) and relevant consults (e.g. geriatrician, psychiatry, neurology), as applies
- ☐ BSO Mobile LTC Team Initial PIECES Assessment (if there is/was BSO involvement)

Please send a copy of any completed cognitive (e.g. MMSE) or mood (Cornell Depression Scale) screens. We encourage the completion of the HNHB Responsive Behaviour Checklist. **Incomplete referrals will be returned to the Director of Care. Please call the office if URGENT.**

Resident Information:

Surname: _____ First Name: _____ M ○ F ○ Marital Status: _____

Date of Birth: YYYY/MM/DD Age: _____ Health Card #: _____ Version Code: _____ Date of Admission to LTCH: YYYY/MM/DD

LTCH Facility Information:

Name of Long Term Care Home: _____ Unit: _____

Facility Street Address: (Number and Name) _____ City: _____ Postal Code: _____

Facility Phone: _____ Facility Fax: _____

Name of Person Completing Referral Form: _____ Role: _____ Contact Phone Number/Ext.: _____

Name of Attending Physician: _____ OHIP Billing Number: _____

Physician Signature: _____ Date: YYYY/MM/DD

Director of Care Signature: _____ Date: YYYY/MM/DD

If capable, has the referred resident person consented to the referral? ○ Yes ○ No

OR

If resident is not capable, has the POA- PC or SDM consented to referral? ○ Yes ○ No

Name of POA-PC/SDM/Public Guardian: _____ Relationship to Resident: _____ Phone: _____ Alternate Phone: _____

Please describe the reason for the referral and specific expectations/ request. Include explanation of symptoms, onset and duration of concerns/behaviours: *(this field will expand to hold all text entered upon clicking outside of the box)*

St. Joseph's Healthcare Hamilton, Seniors Mental Health Outreach Services - Niagara Region
110B Unit 107 Hannover Drive, St. Catharine's, ON L2W 1A4
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Current Health Risks:

Please check the current health risks or concerns you have for the resident:

- ☐ Nutritional concern e.g. recent weight loss within the past 3 months? Eating difficulties? Refusal to eat? Adverse changes?
- ☐ Medication adherence/ poly-pharmacy concerns or medication problems e.g. adverse side effects, issues of compliance, > 5 medications?
- ☐ Sleep disturbance problem or altered sleep pattern?
- ☐ Pain - recent onset or chronic pain
- ☐ Chronic medical conditions e.g. thyroid, diabetes, cardiac, respiratory, kidneys
- ☐ Recent falls or mobility changes
- ☐ Other: _____

Dressing:	Bathing:	Feeding:	Continence Care:	Communication:	Mobility or Transfer Aids:
☐ Independent	☐ Independent	☐ Independent	☐ Independent	Preferred Language:	☐ Cane
☐ Supervision	☐ Supervision	☐ Supervision	☐ Supervision	☐ English	☐ Walker
☐ Total Assist	☐ Total Assist	☐ Total Assist	☐ Total Assist	☐ Other: _____	☐ Wheelchair
			☐ Incontinent Bladder	☐ Translator Needed	☐ Mechanical Lift
			☐ Incontinent Bowel	☐ Hearing Impaired	☐ Other: _____
				☐ Visually Impaired	

Does the resident have a psychiatric history or history of mental illness? ◯ Yes (please explain) ◯ No ◯ Unknown

Current Mental Health Risks:

Please check the current mental health risks or concerns you have for the resident:

- ☐ Changes in mood or affect (high or low)
- ☐ Current/past suicidal thoughts/behaviour/attempts
- ☐ Current/past homicidal ideation
- ☐ Memory loss/cognitive decline
- ☐ Delusions/hallucinations
- ☐ Anxiety/agitation
- ☐ Substance misuse/abuse
- ☐ Other: _____

Other Risks:

Please check any other current risk issues or concerns:

- ☐ Wandering/leaving unsupervised/exit seeks
- ☐ Refusing or resisting care/treatment (refuses meds or therapies)
- ☐ Hoarding, collecting or rummaging / Territorial
- ☐ Agitated behavior - restless, pacing, pleading, calling out, repetitiveness, fearful
- ☐ Verbally responsive behaviour-using obscenity, verbally abusive, angry behaviour
- ☐ Physically responsive behaviour-spitting, kicking, grabbing, pushing, throwing, hitting others
- ☐ Other: _____
- ☐ Sexual behaviour-suggestive remarks, grabbing, touching, exposing self
- ☐ Low mood and/or withdrawal/isolation. Refuses to participate/ no interest (a change from normal routine)
- ☐ Verbalizing thoughts or plan to harm self
- ☐ High caregiver stress
- ☐ Resident on 1:1 or plan to initiate 1:1
- ☐ Police or other crisis/emergency services have been involved

Assessments/interventions tried or resources accessed:

- ☐ DOS Charting
- ☐ Responsive Behaviour Checklist
- ☐ Behaviour Huddle
- ☐ Responsive Behaviour Team Review
- ☐ PRC Consulted
- ☐ Confusion Assessment Method (CAM-delirium screen)
- ☐ BSO Mobile LTC Team involved
- ☐ NLOT or Nurse Practitioner Consulted
- ☐ Other interventions or resource: _____

Has the resident seen any specialists (e.g. Geriatrician, Psychiatrist, and/or other Mental Health provider) in the past? ◯ Yes ◯ No ◯ Unknown

Name of Specialist: _____ Phone: _____ Date of Consultation: YYYY/MM/DD

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