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 behavioursupport@baycrest.org

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

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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 Canada's #1 Hospital

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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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*