Virtual Behavioural Medicine Consultation Program

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

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

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

Program description: VBM aims to support management of neuropsychiatric symptoms (NPS)/responsive behaviours and prevent unnecessary admissions to specialized behavioural units, as well as ED visits, and operates in collaboration with the existing care team and Behaviour Supports Ontario. **Eligibility criteria:** A diagnosis of dementia with unmanaged NPS (responsive behaviours). If geriatric psychiatry has been involved, the referral should ideally be made with agreement from geriatric psychiatry. A Behaviour Supports team is recommended to be involved when available. Referrals will be assigned to Baycrest or Toronto Rehab by an intake clinician.

Referral Date (dd/mm/yyyy): ______________________ **Client Preference:** ☐ Baycrest ☐ Toronto Rehab ☐ Next Available/No Preference

Client Information

Name (last, first): ________________________ **Gender:** __________ **D.O.B (dd/mm/yyyy):** ______________

Health Card #: ____________________ **VC**: ______ **HCN Expiry**: __________ **Languages:** ______________

Name of SDM/POA: ________________________ **Relationship to client:** ______________ **SDM** ☐ **POA** ☐

Phone #: ______________ **Email:** ______________________________

Current Client Location and Address: ________________________ **Unit:** ____ **Unit phone number:** __________

Region:__________ **Family Physician:** ________________________ **Billing #:** ______________

Patient has been deemed incapable of making healthcare decisions ☐ **Yes** ☐ **No**

SDM/POA consents to being referred to the Virtual Behavioural Medicine (VBM) Consultation Program at Baycrest and/or Toronto Rehabilitation Institute and other related programs that the care team identifies may be beneficial to their care. ☐ **Yes** ☐ **No**

Primary Contact (for scheduling and information gathering):

Name: ________________________ **Role:** __________ **Organization:** ______________

Phone #: ______________ **Email:** ______________________________

Location to send prescriptions: ________________________________ **Fax#:** ______________

Reason for referral: ____

Dementia diagnosis known: ☐ **Yes** ☐ **No If yes, please select:** ☐ 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 and is in agreement with VBM referral?** ☐ **Yes** ☐ **No**

If applicable: Psychiatrist's Name: ________________________________

Phone:__________ **Fax:** __________ **Email:**________________________

Additional medical diagnoses: ____

Behavioural issues identified related to reason for referral (please check off the relevant issues):

- ☐ **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**
- ☐ **Resists Care** (incld. medications/injections)
- ☐ **Destroying property**
- ☐ **Verbally responsive behaviour** (yelling, screaming, threatening, cursing etc.)
- ☐ **Agitated behaviour** (restless, anxiety, inability to settle)
- ☐ **Delusions** (fixed, false beliefs)
- ☐ **Hallucinations** (visual, auditory, gustatory, tactile, olfactory)
- ☐ **Fidgeting/picking/repetition**
- ☐ **Calling out, crying**
- ☐ **Hoarding** (collecting objects and refusing to part with them)
- ☐ **Oral intake of non-edible items/substances**
- ☐ **Low Mood/Depressed** (crying, tearfulness, reduced social interaction, loss of interest/pleasure)
- ☐ **Rummaging** (touching/handling objects with no obvious purpose
- ☐ Other: Click here to enter text.

Behaviour Supports (BS) Services Involved: ☐ **Internal BS Services** ☐ **External BS Services** ☐ **No access to External BS Services**

BS Clinician Name: ____________________ **BS Service Organization:** ______________ ☐ **Internal** ☐ **External**

Phone #: ______________ **Email:** ______________________________

Referring Provider: ***(Please note all VBM referrals require a Physician/NP Billing Number & Signature)***

Referring MD/NP: ________________ **Billing #:** ________ **MD/NP Signature:** ____________________

Please attach the following information below:

- ☐Current medication list and/or Medication Administration Record (MAR)
- ☐Neurology/psychiatry consultation notes (if exist)
- ☐Blood work results (if available)
- ☐Next of kin/POA /Substitute Decision Maker documentation
- ☐Cognitive assessments (if available)
- ☐Behaviour Supports (BSO)/Nursing progress notes

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Updated November 2023