Waterloo Wellington
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CCAC CASC
Community Care Access Centre | Centre d'accès aux soins communautaires

GRAND RIVER HOSPITAL
Advancing Exceptional Care

Reviewed by:

Patient Label

NEUROBEHAVIORAL (NBU) AND GERIATRIC (GAU) ASSESSMENT FORM

REQUESTED SERVICES

□ Neurobehavioral Assessment □ Geriatric Assessment

ADMISSION DEMOGRAPHICS - PATIENT'S PERSONAL INFORMATION

Last Name	First Name			☐ Male ☐ Female
Current Address:	Apt #	City	Prov.	Postal Code:
Home Telephone:	Date of birth (YY/MM/DD)		Age:	
Family Physician: Phone: Fax:	Most Responsible Physician/Specialist: Phone: Fax:			
Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No Primary Language: ☐ English ☐ French ☐ Other _____				EDD: _____

HEALTH INSURANCE INFORMATION

Health Card Number: _____ Version Code (if Applicable):_____

Private Insurance Coverage: □ Yes □ No □ Unknown Preferred Accommodation: □ Private □ Semi Private □ Ward

EMERGENCY CONTACT INFORMATION

Next of Kin / Primary contact:	Relationship: ☐POA ☐ SDM ☐Spouse ☐ Other: _____			
Address:	Apt#	City	Prov	Postal Code
Telephone (home):	Telephone (work):		Ext:	
Power of Attorney: □ Personal Care Name:		□ Financial Care Name:		
□ Substitute Decision Maker Name:				

REFERRAL SOURCE

Facility / Community agency:	Sending Unit:	
Primary Contact/Bed Offer Person (Referral Source):		
Phone:	Pager:	Fax:
Secondary Contact/Bed Offer Person (Referral Source):		
Phone:	Pager:	Fax:

DIAGNOSIS

Current Medical Diagnosis:	Relevant Consults List / Pending Investigations:
Relevant Co-Morbidities:	
Scheduled Lab Tests:	
Medical Prognosis:	
Surgical Date: (If applicable)	Attached: □ Yes □ No

PLANNED DISCHARGE DESTINATION

□ Supportive/ Assistive Care	□ Home with Support: _____
□ Retirement Home	□ Other: _____
Name of Retirement Home: _____	□ Reviewed plan of care _____

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BARRIERS & CHALLENGES TO DISCHARGE (Clearly identify expected outcomes of admission)

□ Yes □ No If yes, describe below (*e.g. Homeless, family dynamic, mental health*)

_____

_____

_____

□ Previous Community Supports:

□ Smoking □ Alcohol

NEUROBEHAVIOURAL OR GERIATRIC ASSESSMENT

Specialized Geriatric Assessment Completed (Specify – Geriatric Psychiatrist, Geriatrician, GEM Nurse, Geriatric CNS, other specialized community geriatric assessor, and date):

_____

_____

_____

☐ Public Guardian & Trustee If Yes, name: _____

☐ Justice System Involvement

FUNCTIONAL STATUS & GOALS (Please complete the table below):

I= Independent S= Supervision minA= Assist modA= Moderate Assist maxA= Max Assist D= Dependent NA=Not Available

Activity	Premorbid Status:	Current Status	Required Status to achieve discharge plan (SMART GOALS)	Demonstrated Recent Progress
Bathing				
Bladder Continence				
Bowel Continence				
Communication				
Dressing				
Feeding				
Sitting				
Stairs				
Swallowing				
Toileting				
Transfers				
Walking				
Wheelchair Mobility				

FUNCTIONAL COGNITIVE STATUS (Please complete table below using "intact' or "impaired")

Applicant must demonstrate consistent carryover of learning within current level of cognitive functioning

Element	Premorbid Status:	Current Status:	Required Status to achieve discharge plan (SMART	Demonstrated Recent Progress
Carry-over/New learning				
Ability to follow instructions				
Orientation (person, place, time)				
Insight				
Judgment				

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Identified Behaviors

□ Exit-Seeking □ Resisting Care □ Sun downing □ Physical Aggression □ Need for Constant Observation
□ Delirium □ Verbal Aggression □ Wandering □ Agitation □ Other _____
□ Behaviour Management Strategy _____ □ Attached □ Diagnosed Dementia _____
Restraints Required: □ Physical _____ □ Chemical _____ □ None _____ □ Bed Alarm _____

MOCA Score (when available) : Depression Score (when available):

CLINICAL ALERTS (Please provide details where available. Indicate "NA" if not applicable):

□ MRSA □ VRE □ C Diff □ Other: _____ Current Isolation Status □ Yes □ No □ CPR status :
□ Scheduled Medical Investigations / appointments: _____ □ Infection or Lab Report
Allergies: (Medication, Environmental, Food) _____ □ Documents attached

COMPLETE ALL THAT IS APPLICABLE TO PATIENT STATUS

Tracheostomy:
□ Type: _____
□ Size : _____
□ Cuffed
□ Cuffless
□ Inner Cannula

□ **Suction**
□ Frequency _____
□ Type: _____
□ Size : _____

□ **BiPAP** (pt must bring own machine)

□ **CPAP** (pt must bring own machine)

□ **Oxygen flow L/m:** _____
□ NP □ venti-mask □ high humidity
□ RT Required
□ Breath Stacking: □ Yes □ No

□ **Long Term Ventilator:** □ **Yes** □ **No**
□ Hrs/Day _____
□ Mode _____
□ RT Required
□ Assisted Cough/Breath Stacking
□ Cough Assist

□ **Chest X-ray**
Date: _____
(must be 90 days before admission)

Other Interventions:
□ Halo
□ Orthosis
□ Pleuracentesis
□ Paracentesis

□ **Pain Management Strategy:** □ Yes □ No
Controlled with Oral Analgesics: □ Yes □ No
Medication Pump: □ Yes □ No

□ **Pain Pump**:
□ Type:_____
Epidural: □ Yes □ No
Has Pain Plan Been Started: □ Yes □ No

□ **Wound** Location: _____
□ See Wound Report

Time to Complete Dressing:
□ Less than □ Greater than : 30 Minutes
□ Fistula
□ Perm Catheter
□ Drain Care

□ **IV Therapy /** □ **Lock** : _____

□ **Central Line:**
□ Type:_____

□ **Picc Line** :_____

□ **Drains** _____
□ Catheter
□ Suprapubic
□ Size: _____

□ **Ostomy/Colostomy:***
□ Independent
□ Assist
□ Ostomy supplies – See report

* Patient to provide own, or cover own costs

Weight: _____ Height: _____

□ **Diet Type** : _____
□ Diet Texture :
□ Swallowing or SLP Consult Completed
□ TPN _____

Tube Feed Route:
□ Nasogastric (NG) Tube
□ Jejunostomy (J) Tube
□ Gastric (G) Tube
□ Other_____

□ **Dialysis**
□ Hemo/Schedule: _____
□ Contact to Renal Clinical to determine medical stability and site option for dialysis
□ Location: _____

□ **Peritoneal Dialysis**
□ Run-day/time: _____
□ Independent □ Assist
□ Cycler
□ Twin Bag

□ **Chemotherapy:**
□ Frequency: _____
□ Duration: _____
□ Location: _____

□ **Radiation:**
□ Frequency: _____
□ Duration: _____
□ Location: _____

□ One Person Transfer
□ Two Person Transfer

□ Special Equipment: (include all measurements) □ Yes □ No
Measurements: _____
□ Specialty Bed / Mattress (eg Bariatric, air mattress) _____
Specify height & weight: _____

□ Negative Wound Pressure Therapy (e.g. VAC): _____
□ Other: _____

RELEVANT ATTACHMENTS (Please provide the following if not available to the receiving organization electronically)

□ Most recent Patient History and relevant consult notes
□ RAI-CCRS (MDS) when available
□ Chest X-ray Results
□ Progress notes summarizing current medical condition (w/i last 72 hours)
□ Medication list (BPMH)
□ Last Relevant Lab Results

Fax application to GRH Freeport team: (519) 749-4326