Specialized Mental Health - Seniors' Inpatient Services

Specialized Mental Health
Grand River Hospital - Freeport Site
3570 King St East
Kitchener, Ontario
N2A 2W1

Prior to faxing - please call the program secretary at (519) 749-4300 ext. 7472
Send completed referrals to the attention of the Seniors Intake Co-ordinator**, Specialized Mental Health**
Fax number: (519) 894-8308

Please note that incomplete or missing information on this referral form may delay the decision making process

Date of Referral (MM/DD/YYYY): _____

Referral Source

Agency/Clinician: _____

Contact Name: _____

Address: _____

_____

Phone Number:_____ Fax Number: _____

MRP:_____

Has the client been referred elsewhere? : □ Yes □ No
If yes, please describe:_____

SECTION A - Client Information
Name:
Address:
Phone Number: Home: _____ Work: _____ Can a message be left on the client's voicemail? ☐ Yes ☐ No ☐ N/A Can a message be left with family? ☐ Yes ☐ No
Health Card Number: Version Code:
Date of Birth (MM/DD/YYYY): _____ Age: _____ Gender: _____Marital Status _____
Emergency Contact: _____ Phone Number: Home: _____ Work: _____

Relationship to Client: _____

CPR Status: ☐ Full code ☐ No code ☐ Not discussed

Residential Status

☐ Private Home/Apt ☐ Assisted Living / Group Home ☐ Long Term Care Facility

☐ Hospital (psychiatric) ☐ Hospital (non-psychiatric) ☐ Homeless

☐ Retirement Home ☐ Shelter

Income

☐ Employment ☐ Social Assistance (OW) ☐ ODSP ☐ Employment Insurance

☐ Family ☐ No source of income ☐ Pension ☐ CPP

☐ Trillium Drug Program ☐ OAS ☐ other_____

Section B: Reason for Referral

Psychiatric diagnosis & history (include dates of ER visits and hospitalizations, substance abuse):_____

Medical diagnosis & history:_____

Presenting Problem: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Goals for Admission: _____

_____

_____

Please provide information regarding referrals and discharge plans that have been considered for this client or that have been completed?

_____

_____

Section C: Legal Information (MHA, Consent and Capacity)

Is client currently certified under the MHA? ☐ Yes ☐ No

If yes, which Form: _____ Issue Date: _____ Expiry Date: _____

Is client capable to manage Personal Care ☐ Yes ☐ No

If no, SDM/POA: _____Tel: _____Relationship:_____

Date of most recent capacity assessment for property, if assessed (MM/DD/YY): _____

Is client capable to manage Property ☐ Yes ☐ No

If no, SDM/POA: _____Tel: _____Relationship:_____

Date of most recent capacity assessment for property, if assessed (MM/DD/YY): _____

Is the client currently on a Community Treatment Order? ☐ Yes ☐ No
(If yes, please attach a copy of the Community Treatment Plan)

Is there a consent and capacity board pending for this client? ☐ Yes ☐ No

Does the client have any current, or past, legal involvement (current charges, probation, etc.)? ☐ Yes ☐ No
Specify:_____

Driver's license status: ☐ Active ☐ Suspended ☐ Client does not have a driver's license

SECTION D – Behavioural Issues (current & past)

	Yes	No	If yes, when?	Comments
Wanders/Pacing	☐	☐		
Exit Seeking	☐	☐		
Sleep Disturbance	☐	☐		
Fire Setting	☐	☐		
Suicidal Behaviour	☐	☐		
Self-Harming Behaviour	☐	☐		
Homicidal Behaviour	☐	☐		
Hoarding Behaviour	☐	☐		
Anxious Behaviour	☐	☐		
Noisy/Vocalizing	☐	☐		
Potential Injury to Self or Others	☐	☐		
Inappropriate Sexual Behaviour	☐	☐		
Suspicious Behaviour	☐	☐		
Ingestion of Foreign Substances	☐	☐		
Responsive Behaviours to Personal Care	☐	☐		

Behavioural triggers (Physical, Intellectual, Emotional, Environmental, Social):
_____
_____
_____
Indicators of behavioural escalation:
_____
_____

De-escalation techniques that are successful:_____
_____

Behavioural interventions attempted that are **NOT** successful:_____
_____
_____

SECTION E– Mental Status / Cognitive Function

COGNITIVE FUNCTION

Oriented to: ☐ Person ☐ Place ☐ Time

Memory impairment: ☐ Mild ☐ Moderate ☐ Severe

Attention impairment: ☐ Mild ☐ Moderate ☐ Severe

Coordination & spatial orientation impairment: ☐ Mild ☐ Moderate ☐ Severe

Hallucinations: ☐ yes ☐ no
Describe:_____

Delusions: ☐ yes ☐ no
Describe:_____

MMSE_____ Date:_____
MoCA_____ Date:_____
GDS_____ Date: _____
CAM_____ Date:_____

Specify Any Recent Changes to mental status/cognitive function:
_____

SECTION F – Communication

Expresses needs verbally: ☐ yes ☐ no

Follows verbal instructions: ☐ yes ☐ no

Eye wear: ☐ yes ☐ no

Hearing Aids: ☐ yes ☐ no

Language spoken: _____

SECTION G - Functional Assessment

Ambulation: ☐ Independent ☐ Assisted ☐ Dependent

Transfers: ☐ Independent ☐ Assisted ☐ Dependent

Wheelchair: ☐ Yes ☐ No

Date of last fall and situation :_____ _____
Number of falls in past 2 weeks:_____

Washing/Dressing: □ Independent □ Assisted □ Dependent
Toileting: □ Independent □ Assisted □ Dependent
Grooming: □ Independent □ Assisted □ Dependent

Equipment used for ADLs/moblity:_____
_____

Does the client require support with any of the following:

☐ Money Management ☐ Homemaking ☐ Meal Preparation ☐ Transportation

☐ Other _____

BOWEL ☐ Continent ☐ Incontinent ☐ History of Constipation ☐ Ostomy

BLADDER ☐ Continent ☐ Incontinent ☐ Catheter ☐ History of UTI Date of last UTI:_____

SKIN

Intact & clear ☐ Yes ☐ No

Past history skin breakdown ☐ Yes ☐ No

Not Intact: Stage_____ Size:_____ Location:_____ Description:_____ _____

Prescribed treatment: _____ Improving ☐ Yes ☐ No

Specialty mattress and/or wheelchair cushion in use? ☐ Yes ☐ No
If yes, specify:_____

Foot care required: ☐ Yes ☐ No

Section H – Nutrition

Height:_____ Weight:_____

Recent change in weight? ☐ Yes ☐ No If yes, specify:_____

Feeding: ☐ Independent ☐ Set-up ☐ Assisted

Choking Risk: ☐ Yes ☐ No

Dietary Restrictions: ☐ Yes ☐ No If yes, specify:_____

Dentures: ☐ N/A ☐Full ☐ Top ☐ Bottom ☐ Partial

Section I - Safety Requirements

Physical Restraints: ☐ Yes ☐ No

If yes, specify: Why? _____When? _____

Please specify type of physical restraint & falls management tools currently in use:

☐ bed rails ☐ wheelchair ☐ low bed ☐ bed alarm ☐ Broda chair ☐ pelvic restraint ☐ seat belt

☐ floor mat ☐ chair alarm ☐ secure unit ☐ Other:_____

Section J - Special Needs

☐ Suction (Frequency)_____ ☐ Oxygen

☐ Glucometer Checks (Frequency):_____ ☐ Other _____

☐ CPAP:_____

Precautions Required: ☐ VRE ☐ MRSA ☐ C. Difficile ☐ Other:_____

Section K – Social History

Family supports/interaction:

Community Supports (list providers, type, frequency, intensity of support, current and past):

INCLUDE THE FOLLOWING DOCUMENTS WITH THIS REFERRAL:

☐ Assessments completed (psychiatry, psychology, occupational therapy, social work, etc.)

☐ Recent progress notes

☐ Copy of most recent MAR

☐ Recent lab results

☐ P.I.E.C.E.S. review from the Psychogeriatric Resource Consultant (PRC)

☐ Copies of behavioural tracking tools (Dementia Observation Scale, Cohen-Mansfield Agitation Inventory, etc.)

☐ Copy of latest MoCA or MMSE or Clock Drawing

☐ Medical screen for psychiatric patients form completed

☐ Other relevant information: _____

Medical Screening for Psychiatric Patients

PHYSICAL EXAMINATION

VITAL SIGNS
BP ____ HR ____ RR____ Temp____

GENERAL APPEARANCE HEIGHT ____ WEIGHT ____
SKIN Intact Not Intact

HEENT
Thyroid Exam Details:
Tympanic membranes Details:
Neck ROM Exam Details:
Oral Exam Details:
Cervical Lymph Nodes Details:

CVS
Heart auscultation Details:
Carotid bruits Details:
Peripheral pulses Details:
Peripheral edema Details:

RESPIRTORY
Lungs auscultation Details:

ABDOMEN
Bowel Sounds Details:
Palpation Details:
Liver Details:

Neurological Exam
Cranial Nerve Exam Details:
Motor Exam Details:
Distal Sensory/Vibration Exam Details:
Gait/Station Exam Details:

GENITALIA/PELVIC/RECTAL EXAM
Not Indicated due to absence of symptoms
Indicated due to symptoms, Details:

SUPPLEMENTARY TESTING
MMSE score (if indicated, with appropriate documentation) _____

Labs only for **positive** findings:
CBC, Electrolytes, BUN, Creatinine
Urine and bld. for Toxicology
CXR
Pregnancy Test

I have performed the physical exam: _____
Physician/Nurse Practitioner Signature

(Patient Label)

MENTAL HEALTH AND ADDICTIONS - CONSENT FORM

I, the undersigned, do hereby authorize and give consent to participate fully in the following program:

Program Requested	Facility Requested
☐ **General Rehabilitation**	☐ **Cambridge Memorial Hospital**
☐ **Functional Enhancement**	☐ **Grand River Hospital**
☐ **General Complex Medical**	☐ **Groves Memorial Community Hospital**
☐ **Chronic Ventilator/Respiratory**	☐ **St. Joseph's Health Centre Guelph**
☐ **Neurobehavioural Assessment**	
☐ **Geriatric Assessment**	
☐ **Specialized Mental Health- Seniors' Inpatient Services**	

I understand this means:

1. I have discussed the requested program with

   _____.
   (Print Name of Referral Source)

2. I fully understand what the program is and what is expected of me as a patient participating in the program.

I authorize the release of my personal and medical information to the requested program.

Name of Power of Attorney/Substitute Decision Maker (if applicable):

_____

_____ _____
Signature of Patient/Power of Attorney/Substitute Decision Maker Date

_____ _____
Signature of Witness Date

_____ _____
Name of Individual Obtaining Consent Date