WRHN
Waterloo Regional
Health Network

# Specialized Mental Health - Seniors' Inpatient Services

**Specialized Mental Health**
**WRHN @ Chicopee**
**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: _____<br>Can a message be left on the client's voicemail? ☐ Yes ☐ No ☐ N/A<br>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: _____<br>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** | ☐ **WRHN @ Chicopee** |
| ☐ **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