Ontario Health atHome

Patient Label

Reviewed By:

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 #: VC: 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:

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

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

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☐ 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 GOALS)	Demonstrated Recent Progress
Carry-over/New learning				
Ability to follow instructions				
Orientation (person, place, time)				
Insight				
Judgment				

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):

Ontario

HOME AND COMMUNITY CARE SUPPORT SERVICES
Waterloo Wellington

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CLINICAL ALERTS (Please provide details where available. Indicate "N/A" 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	**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	**Diet Type:** ☐ Diet texture: ☐ Swallowing or SLP consult completed ☐ TPN:
☐ **Suction:** Frequency: Type: Size: ☐ **BiPAP** (Pt must bring own machine) ☐ **CPAP** (Pt must bring own machine)	**Wound Location:** ☐ See Wound Report Time to complete dressing: ☐ < 30 mins ☐ > 30 mins ☐ Fistula ☐ Perm Catheter ☐ Drain Care	**Tube Feed Route:** ☐ Nasogastric (NG) Tube ☐ Jejunostomy (J) Tube ☐ Gastric (G) Tube ☐ Other:
☐ **Oxygen Flow L/min:** ☐ NP ☐ Venti-mask ☐ High humidity ☐ RT required Breath Stacking: ☐ Yes ☐ No	☐ **Negative Wound Pressure Therapy (NWPT):** (E.g. VAC): ☐ Other:	☐ **Dialysis:** Hemo/Schedule: ☐ Contact to Renal Clinical to determine medical stability and site option for dialysis ☐ Location:
☐ **Long-Term Ventilator:** Hrs/Day: Mode: ☐ RT required ☐ Assisted Cough/Breath Stacking ☐ Cough Assist	☐ **IV Therapy/Lock:** ☐ Central Line: Type: ☐ PICC Line: ☐ Drains: ☐ Catheter ☐ Suprapubic Size:	☐ **Peritoneal Dialysis:** Run-day/Time: ☐ Independent ☐ Assist ☐ Cycler ☐ Twin Bag
☐ **Chest X-Ray:** Date: *(Must be 90 days prior to admission)	☐ **Ostomy/Colostomy: *** ☐ Independent ☐ Assist ☐ Ostomy supplies – See report *Pt to provide own, or cover own costs Weight: Height:	☐ **Chemotherapy:** Frequency: Duration: Location:
☐ **One-Person Transfer** ☐ **Two-Person Transfer**	**Other Interventions:** ☐ Halo ☐ Orthosis ☐ Pleuracentesis ☐ Paracentesis	☐ **Radiation:** Frequency: Duration: Location:
☐ Special Equipment (include all measurements): Measurements:		☐ Specialty Bed/Mattress (E.g. Bariatric, air mattress): Specify height & weight:

RELEVANT ATTACHMENTS (Please provide the following if 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 (within last 72 hours) ☐ Medication list (BPMH) ☐ Last Relevant Lab Results

*****Fax application to WRHN @Chicopee team: (519) 749-4326*****