OFFICE USE ONLY
Date Referral Received: ____________________
Received by: ______________________________
Feedback to referring agency: ☐ Yes ☐ No
Referral Complete: ☐ Yes ☐ No
If no, please return to referring agency with request to complete.

Specialized Mental Health Seniors Inpatient Referral

3570 King St. East, Kitchener, Ontario N2A 2W1

Date of Referral:

Referral Source
Referring Physician:
Agency:
Contact Name:
Phone Number:

Please Affix Patient Label

Eligibility Criteria:

Please review the eligibility and check off that patient meets the following criteria:

- ☐ Resident of Waterloo Wellington (Kitchener, Waterloo, Cambridge, Guelph, Wellington, Wellesley, Wilmot, and Woolwich areas)
- ☐ Has been diagnosed with Major Neurocognitive Disorder (MNCD), moderate to severe stages with frequent behaviour and psychological symptoms of dementia (BPSD)that pose a safety risk to the patient and/or others
- ☐ Has accessed less intrusive interventions and supports (i.e. Behaviour Supports Ontario (BSO), Psychogeriatric Resource Consultant (PRC), Geriatric Psychiatry)
- ☐ Acute, unstable medical issues (i.e. delirium) have been ruled out or resolved
- ☐ Does not require oxygen therapy greater than 4L/min.

Additional Information:

- ☐ At risk of losing their accommodation in their LTC/retirement home OR those experiencing challenges related to LTC eligibility due to the severity and/or frequency of their BPSD
- ☐ Requires three or more staff to provide personal care and/or constant care and/or restraints and/or seclusion

The referrals process:

- Completed referral packages will be reviewed with the Intake Committee and will notify the referrer of the decision within 7 calendar days.
- It is expected that patients who are waiting for admission after acceptance will continue to receive active treatment and disposition planning.
- Please note that acceptance to our waitlist does not necessarily mean admission to our program. The Intake Coordinator will liaise with you while your client is on our waitlist. If the client stabilizes and/or no longer meets our eligibility criteria they will be removed from our waitlist and the referral will be cancelled.
- Please call the Intake Coordinator if you determine that your client no longer requires the intensity of our program.
- Please note that medical stability will need to be confirmed prior to a bed offer.
- For questions please call: (519) 749-4300: Ext 7472 (Program Secretary) or Ext 7050 (Intake Coordinator)
- Fax completed referrals to the attention of the Seniors Intake Coordinator, Specialized Mental Health. Fax number: (519) 894-8308

Incomplete or missing information will delay the decision making process

Client Name: ______________________________

SECTION A - Client Information

Name:		MRN:
Address:		
Phone Number:		
Health Card Number:	Version Code:	Expiry (YY-MM-DD):
Date of Birth (MM/DD/YYYY):	Age:	Gender:
Family Physician:		Phone:
Primary Contact: Relationship to Client:		Phone Number: E-mail:

Residential Status:

☐ Private home/apt ☐ Assisted Living / Group Home ☐ Long-term Care Home
☐ Hospital (psychiatric) ☐ Hospital (non-psychiatric) ☐ Retirement Home
☐ Shelter ☐ Unhoused

Is client currently in hospital? ☐ Yes ☐ No

If no, where is client being referred from?

If yes, date of Admission: (MM/DD/YY):

Has the SDM been informed of the referral being submitted? ☐ Yes ☐ No

If in hospital, does this person meet the criteria for Alternate Level of Care (ALC)? ☐ Yes ☐ No

SECTION B – Reason for Referral

Current Behavioural and Psychological Symptoms:

Relevant medical diagnosis and history:

Goals for admission/discharge:

Client Name: ________________________________

Section C – Community Supports

Family Physician:	Number:
Psychiatrist:	Number:
Pharmacy:	Number:
Mental Health:	Number:
Other:	Number:
Other (role):	Number:

SECTION D – Mental Status and Cognitive Function

Oriented to:	☐ People	☐ Places	☐ Time
Short Term Memory Impairment:	☐ Mild	☐ Moderate	☐ Severe
Long Term Memory Impairment:	☐ Mild	☐ Moderate	☐ Severe
Attention Impairment:	☐ Mild	☐ Moderate	☐ Severe
Coordination & Spatial Orientation Impairment:	☐ Mild	☐ Moderate	☐ Severe

Mental Status:

Hallucinations: ☐ Yes ☐ No

Delusions: ☐ Yes ☐ No

Please describe:

Most recent testing:

MoCA:	Assessment Date:
MMSE:	Assessment Date:
GDS:	Assessment Date:
Cornell:	Assessment Date:
CAM:	Assessment Date:
Other:	Assessment Date:

Specify any recent changes to mental status/cognitive function:

Section E – Communication

Language(s) spoken:

Verbal communication:

Understood when speaking:	☐ Always	☐ Sometimes	☐ Never
Understands when spoke to:	☐ Always	☐ Sometimes	☐ Never
Able to follow instructions:	☐ Always	☐ Sometimes	☐ Never

Vision:	☐ Adequate	☐ Impaired
Does the client use eye wear?	☐Yes	☐No
Hearing:	☐ Adequate	☐ Impaired
Does the client use hearing aids?	☐Yes	☐No

Does the client use dentures? ☐ Full ☐ Top ☐ Bottom ☐ Partial ☐ N/A

Client Name: ________________________________

SECTION F – Expressions of Risk

Current Expressions of Risk:

Vocal expressions		**Physical Expressions**		**Other**	
Makes excessive noise	☐	Grabbing	☐	Sleep disturbance	☐
Repetitive vocalizing	☐	Biting	☐	Uninhibited sexual expressions	☐
Anxious expressions	☐	Kicking	☐		
Motor expressions		Pinching	☐		
Exploring/Searching	☐	Hitting	☐		
Collecting items	☐	Pushing	☐		
Rummaging	☐	Scratching	☐		
Disrobing	☐	Slapping	☐		
Ingesting foreign substances	☐	Spitting	☐		
Verbal expressions of risk		Headbutting	☐		
Threatening	☐	Throwing items/furniture	☐		
Screaming	☐	Potential injury to self or	☐		
Swearing	☐	Self-harming	☐		
Vocal expressions		Suicidal expressions	☐		
Makes excessive noise	☐	Homicidal expressions	☐		
Repetitive vocalizing	☐	Suspiciousness	☐		

Details of above:

Known triggers (Physical, Intellectual, Emotional, Environmental, Social):

Indicators of Escalating Risk:

Effective Strategies and Interventions (pharmacological and non-pharmacological):

Client Name: ______________________________

SECTION G - Functional Assessment

Ambulation ☐ Independent ☐ Assisted ☐ Dependent

Transfers ☐ Independent ☐ Assisted ☐ Dependent

Equipment Needed for Above:

Does the client use a wheelchair? ☐ Yes ☐ No Type/measurements:

Does the client own their wheelchair? ☐ Yes ☐ No

Does the client have a history of falls? ☐ Yes ☐ No

Date and context of last fall:

Any injuries sustained?

Activities of Daily Living (ADLs):				**Trigger for expressions?**
Washing	☐ Independent	☐ Assisted	☐ Dependent	☐
Dressing	☐ Independent	☐ Assisted	☐ Dependent	☐
Toileting	☐ Independent	☐ Assisted	☐ Dependent	☐
Grooming	☐ Independent	☐ Assisted	☐ Dependent	☐
Mouth Care	☐ Independent	☐ Assisted	☐ Dependent	☐
Feeding	☐ Independent	☐ Assisted	☐ Dependent	☐

Equipment used for ADLs:

Continence:

Bladder	☐ Continent	☐ Incontinent	☐ Catheter	☐ History of UTI
Bowel	☐ Continent	☐ Incontinent	☐ Ostomy	☐ History of Constipation

Incontinence product(s) used:

SECTION H - Nutrition

Height: Weight:

Recent change in weight? ☐ Yes ☐ No

Changes to swallow? ☐ Yes ☐ No

Risk for choking? ☐ Yes ☐ No

Diet Texture:

Fluid texture:

Dietary Restrictions:

Client Name: ______________________________

SECTION I - Skin

Intact & Clear: ☐ Yes ☐ No
Past history of skin breakdown: ☐ Yes ☐ No
Foot care services required? ☐ Yes ☐ No

If not intact:
Location: Size: Stage:
Description:

Prescribed treatment:
Improving? ☐ Yes ☐ No

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

SECTION J - Safety Requirements

Please specify any physical restraints, personal support assistive devices (PSAD) & falls management tools currently in use:

☐ bed rails ☐ high/low bed ☐ bed alarm ☐ floor mat ☐ door alarm ☐ secure unit
☐ tilt wheelchair ☐ chair alarm ☐ lap tray ☐ seat/lap belt ☐ pelvic restraint ☐ Pinels
☐ Other:

Please describe why and when these interventions are utilized:

SECTION K - Special Medical Needs

☐ Suction (frequency): ☐ Oxygen Therapy
☐ Glucometer Checks (frequency): ☐ CPAP
☐ Other:

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

SECTION L – Current Legal Information (Consent & Capacity)

Is the client capable to consent to treatment? ☐ Yes ☐ No
If no, SDM: Tel:
Is there an appointed attorney(s) for Personal Care? ☐ Yes ☐ No
If yes, name(s): Tel:
Relationship: ***Copy of POA document required on admission day.**

Is client capable to manage property? ☐ Yes ☐ No
Date of most recent capacity assessment for property, if assessed (MM/DD/YY):
Is there an appointed attorney for property (POA)? ☐ Yes ☐ No
If yes, name(s):
Relationship: Tel:

Client Name: ________________________________

Is there a Consent and Capacity Board hearing pending for this client? ☐ Yes ☐ No Date:

If client has any legal involvement, please provide details: (i.e. pending court dates, current status, etc.):

SECTION M – Other information

Please include the following documents with this referral:

- ☐ Completed consent form (**must be completed if referring from outside of hospital)
- ☐ Recent assessments and progress notes
- ☐ Copy of most recent MAR
- ☐ Recent lab results
- ☐ Copies of behavioural tracking tools (Dementia Observation Scale (DOS), Cohen-Mansfield Agitation Inventory (CMAI), etc.) and behavioural care plan.
- ☐ P.I.E.C.E.S. review, if available
- ☐ Relevant social history information, including important cultural and spiritual influences
- ☐ Cumulative Patient Profile if available

SECTION N – Consent Form

I, the undersigned, do hereby authorize and give consent to the referral to the **Specialized Mental Health – Seniors' Inpatient program at WRHN @ Chicopee**.

I understand this means:

- the patient's personal and medical information will be released to the Intake Committee for review and assessment of the patient's eligibility for admission
- the intended purpose of the program is for the treatment and stabilization of Behavioural and Psychological Symptoms of Dementia
- the decision maker is willing to consent to treatment with psychotropic medications in combination with non-pharmacological strategies and interventions
- once treatment has been optimized, the patient is to be discharged to an appropriate care environment

____

Printed name of Power of Attorney/Substitute Decision Maker:

____ ____________________

Signature of Patient/Substitute Decision Maker Date

____ ____________________

Signature of Witness Date

____ ____________________

Name of Individual Obtaining Consent Date

____

Contact number of Individual Obtaining Consent