Peterborough Regional Health Centre

Geriatric Assessment and Behavioural Unit Referral

Patient Label

Date of Referral: _____

(DD/MM/YYYY)

Complete and Fax to: 705-876-5836
Phone: 705-743-2121 Ext. 4303
Please note that incomplete referrals will result in a delay, you will be contacted once the referral has been reviewed

CLIENT INFORMATION:

Name: _____OHIP#: _____ DOB (DD/MM/YYYY): _____Gender: ☐ Male ☐ Female
Address: (include Apt #) _____
Method of contact: (Choose all that you consent to) ☐ Mail ☐ Cell # _____ ☐ Home Phone # _____
Can we leave a message? ☐ Yes ☐ No
Next of Kin/SDM: _____Relationship to Client: _____ Phone #: _____
Language: _____ Is an interpreter required? ☐ Yes ☐ No Is client aware of this referral? ☐ Yes ☐ No

Other Relevant Information

Current Living Arrangements (Date admitted to facility if applicable)**:**

☐ Lives Alone
☐ With Partner/ Spouse
☐ With Children
☐ LTCH_____
☐ Retirement Home_____

Is the client medically stable? ☐ Yes ☐ No
Is the client developmentally delayed? ☐ Yes ☐ No

Contact/ Substitute Decision Maker/ Power of Attorney

Treatment Decisions made by: ☐ Self ☐ Power of Attorney ☐ Public Guardian/ Trustee ☐ Substitute Decision Maker
Contact Name: _____ Relationship: (Spouse, Child, POA, PGT): _____
Address:_____
Home Phone #: _____ Work #:_____ Mobile #: _____

Financial Decisions made by: ☐ Self ☐ Power of Attorney ☐ Public Guardian/ Trustee ☐ Substitute Decision Maker
Contact Name: _____ Relationship: (Spouse, Child, POA, PGT): _____
Address:_____
Home Phone #: _____ Work #:_____ Mobile #: _____

Diagnosis (onset date, who diagnosed)**:**

Current Medical Symptoms/ Current Treatments:

REFERRING SOURCE NAME: _____
Telephone #: _____
Fax: _____
Referral Signature: _____
PRIMARY PHYSICIAN: Name: _____
Telephone #: _____ Fax: _____

Past Psychiatric and Medical History (including substance use):

Reason(s) for the referral: (symptoms, duration and goal, etc.)

Impact on daily functioning: ☐ Mild ☐ Moderate ☐ Severe

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Current Responsive Behaviours

Please check all that apply:

- ☐ Verbally Responsive
- ☐ Physically Protective
- ☐ Collecting Items
- ☐ Depression
- ☐ Suicide Ideation
- ☐ Suicide Attempt
- ☐ Restless/Pacing
- ☐ Threat to Self
- ☐ Repetitive Vocalizations
- ☐ Resist/Refuse Personal Care
- ☐ Exit-Seeking
- ☐ Psychotic Symptoms (hallucinations, delusions)
- ☐ Disrobing
- ☐ Indiscriminate Ingestion of Foreign Substances
- ☐ Sexually Expressive
- ☐ Resist/Refuse Treatment
- ☐ Sleep Disturbance
- ☐ Other: _____

Provide additional details and describe responsive behaviours:

Activities of Daily Living

Dressing:	☐ Independent	☐ Supervision	☐ Limited Assistance	☐ Extensive Assistance	☐ Total Care (# of staff to provide care: ____)	
Bathing:	☐ Independent	☐ Supervision	☐ Limited Assistance	☐ Extensive Assistance	☐ Total Care (# of staff to provide care: ____)	
Feeding:	☐ Independent	☐ Supervision	☐ Limited Assistance	☐ Extensive Assistance	☐ Total Care (# of staff to provide care: ____)	
Transfers:	☐ Independent	☐ Supervision	☐ Assistance X1	☐ Assistance X2	☐ Assistance X3	☐ Mechanical Lift
Ambulation:	☐ Independent	☐ Supervision	☐ Assistance X1	☐ Assistance X2	☐ Assistance X3	☐ Non-ambulatory
Bowel Continence:	☐ Incontinent	☐ Continent				
Bladder Continence:	☐ Incontinent	☐ Continent				
Client uses:	☐ Glasses	☐ Hearing Aid	☐ Dentures	☐ Cane	☐ Walker	☐ Wheelchair

Checklist

- ☐ Past two weeks of nursing notes
- ☐ Lab results including urinalysis within one month
- ☐ Delirium Screen (CAM, I WATCH DEATH)
- ☐ Consults
- ☐ Diagnositic Imaging (Chest xray,ECG, CT, MRI) if available
- ☐ Power of Attorney Documentaiton
- ☐ Current Medication Use/ MAR
- ☐ Advance Directive
- ☐ Behaviour Care Plan/B.A.T
- ☐ MRSA/VRE Screen within two weeks
- ☐ Assessments (DOS, RAI/MDS, Cohen Mansfield Agitation Inventory, Cornell Scale for Depression, Pain Assessments, Cogntive Assessment etc. if available)
- ☐ Signed Consent for Treatment
- ☐ Signed Reciprocating Agreement

CURRENT MEDICATIONS (Psychiatric) attach additional information if needed

Medication	Dose / Frequency	Response & Adverse Effects

Past Medications (Psychiatric*)*

Medication	Dose / Frequency	Response & Adverse Effects

Allergies:

Past Psychiatric Assessments or Therapies ☐ Yes ☐ No ☐ **Documents attached to referral form**

Please note, in order to process referral request any previous psychiatric assessments or therapy reports/documents must be attached to referral form

Other involved Care Providers: (LHIN, ON Shores, PASE, GAIN etc.)	**Referrals/Waitlisted for other services? ☐ Yes ☐ No**

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Informed Consent for Admission

We welcome you and/or your loved one to the Geriatric Assessment and Behavioural Unit (GABU). The GABU specializes in assessing and treating responsive behaviours that arise secondary to a diagnosis of dementia. Given that all patients on GABU have been identified as having behaviours, we would like to you to be aware of the types of behaviours you and/or your loved one may see and experience while on the unit. These may include any or all of the following:

Patients in the GABU may exhibit varying behaviours, including the following:

- Physical aggression
- Verbal aggression
- Exit-seeking
- Wandering
- Sexual expression
- Calling out
- Repetitious behaviour
- Rummaging in the belongings of others
- Entering rooms that aren't their own

I, _____ (SDM/POA name, printed), acknowledge that I have

been made aware of the above risks and consent to _____ (name of patient, printed)

being admitted to GABU.

_____ _____

Signature of SDM/POA Date (dd/mm/yyyy)

_____ _____ _____

Name of Witness Signature of Witness Date (dd/mm/yyyy)

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Admission Reciprocating Agreement

Patient ‘s will be accepted for admission in accordance with the Admission Criteria for the Geriatric Assessment and Behavioural Unit at the Peterborough Regional Health Centre (PRHC) as listed below:

- Older adults with a dementia or other age-related cognitive impairment, and associated responsive or challenging behaviours; (may include verbal and/or sexual and/or physical aggression)
- The patient is medically stable
- Acute delirium has been ruled out as the cause of the behavior
- Previous attempts to resolve behaviours as an outpatient in consultation with Geriatric Assessment Intervention Network (GAIN) or Psychiatric Assessment Services for the Elderly (PASE) clinics (where applicable) have been unsuccessful.
- GAIN or PASE Clinics have assessed that the older adult with dementia would benefit from an inpatient assessment and have recommended application to inpatient treatment, or
- Sending hospital has referred a patient who has been reviewed by Geriatric Care Coordinator and Geriatrician/Geriatric Psychiatrist and agreed to the admission.

Once the admission criteria has been reviewed and agreement to accept the patient has been made PRHC requests assurance from the referring institution/unit that they will repatriate the patient /resident/client back once the GABU health care team has determined treatment is completed. Estimated date of discharge from the GABU unit is approximately six to eight weeks post admission to the unit.

GABU Manager/Director: _____

Referring Institution/Unit: _____

The referring institution/unit understands and agrees to be involved in the discharge process to ensure the success of the care plan and treatment continuity upon discharge.

My/Our Signature indicates that I/We have read and understand the provisions outlined in this agreement and agree to the terms.

Dated this ____ day of _____ (Month) _____ (Year)

_____ Signature of Unit Manager/Director of Care

_____ Signature of Unit Manager/Director of Care

_____ Print name of Unit Manager/Director of Care

_____ Print name of Unit Manager/Director of Care