APPLICATION TO BEHAVIOURAL NEUROLOGY
SHORT-TERM ASSESSMENT & TREATMENT UNIT

Request for admission to include a signed referral letter from the referring physician addressed to Dr. Michael Kirzner and copied to Dr. Morris Freedman.

Please send completed applications directly to the Admission Office @ Fax: 416-785-2471

For more information, please contact Shoshana Yaakobi at 416-785-2500 ext. 2319

Date of Application: _____

Patient's Name: _____

Patient's Date of Birth: _____ Male ☐ Female ☐

Referring MD: _____

Address: _____ Tel: _____ ext. _____

_____ Fax: _____

_____

_____

Family MD: _____

Address: _____ Tel: _____ ext. _____

_____ Fax: _____

_____

_____

Referring Contact Person: (if other than above):

Name: _____

Tel: _____ ext. _____

Fax: _____

Facility: _____

NEUROLOGICAL INFORMATION

Patient is being referred to the Behavioural Neurology Unit for: (4 all that apply) ☐ Diagnosis ☐ Treatment

Neurological diagnosis is: _____

_____

_____

Presenting symptoms/problems are: _____

_____

_____

Are specialists involved in this patient's care? **(**4 all that apply) □ Neurology □ Psychiatry □ Geriatric Medicine □ Other

Names of specialists: i) _____

ii) _____

iii) _____

GOALS OF ADMISSION:
(If treatment is a goal of admission, please be as specific as possible concerning which behaviours need to be addressed)

1._____

2._____

3._____

Other Information/Comments:
_____

_____

DISCHARGE PLAN
What is the expected discharge destination for this patient after completion of his/her stay in Behavioural Neurology?

A. Return home □

B. Return to referring facility □

C. Placement in long-term care facility □ (If an application for long-term care has already been completed, please identify the CCAC office/case manager, date of application, and list of facilities chosen).

Please complete and attach the following enclosed documents:

- Completed CCAC application – Medical assessment, signed by referring physician.
  Functional assessment
  Behavioural assessment
- All relevant consultation notes from Neurology and Psychiatry, if applicable.
- Completed and signed take back letter (see attached sample) if patient is being referred from a hospital or Long Term Care facility.

Long-Term Care Placement Application

☐ LONG STAY
☐ SHORT STAY
☐ CONVALESCENT

HEALTH INSURANCE	Ontario Health Card # Version Code	Out of Province Health Card # Prov.	
APPLICANT	Surname Given Names	Gender	Date Of Birth (Y Y Y Y M M D D)
	Permanent Address Apt#	In-Home Service: ☐ No ☐ Yes, District:	
	City Postal Code	Telephone ( )	
WHERE IS APPLICANT NOW?	COMMUNITY: ☐ House ☐ Apartment ☐ with Family ☐ Retirement Home ☐ OTHER (please specify): INSTITUTION: ☐ Acute Care ☐ Assessment ☐ Chronic Care ☐ Rehab Hospital ☐ LTCH Institution Admission Date: (Y Y Y Y M M D D)		
	Address		
	City Postal Code	Telephone ( )	
DEMO-GRAPHICS	Citizenship: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Veteran Service #_____ ☐ Other:	Marital Status: ☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Ethno-Cultural request: Religion: Languages Spoken: 1st 2nd Accommodation(s) requested (see over for rates): ☐ Basic* ☐ Semi-Private ☐ Private ☐ Couple

1. Applicant Contacts

FAMILY PHYSICAN	Surname Given Names	Office: ( )
	Address City Postal Code	Alt: ( )
		Cell: ( )
		Fax: ( )
CONTACT #1 ☐ Substitute Decision Maker ☐ POA-Personal Care (encl. copy)	Surname Given Names	Relationship to Applicant:
	Address	Home: ( )
		Cell: ( )
	City Postal Code	Work: ( )
		Email:
CONTACT #2 ☐ SDM Jointly ☐ POA-Personal Care (encl. copy)	Surname Given Names	Relationship to Applicant:
	Address	Home: ( )
		Cell: ( )
	City Postal Code	Work: ( )
		Email:
FINANCIAL AFFAIRS	☐ SELF ☐ OTHER ☐ Power of Attorney for Property (Finances)	Relationship to Applicant:
	Surname Given Names	Home: ( )
		Cell: ( )
	Address City Postal Code	Work: ( )
		Email:
REFFERED BY	Name	Relationship to Applicant:
	Signature Telephone ( )	Date of Referral (Y Y Y Y M M D D)

2. Background Information, Reason for Application

Ontario Ministry of Health and Long-Term Care / Ministère de la Santé et des Soins de longue durée

Health Report/ Rapport médical

*The purpose of this form is to provide information about the person who is applying for admission to a Long-Term Care facility. Indicate the source of information where appropriate. Please complete in **black** ink and return to Community Care Access Centre within 10 days*

*La présente formule a pour but de fournir des renseignements sur la personne qui fait une demande d'admission dans un établissement de soins de longue durée. Veuillez préciser la source des renseignements fournis s'il y a lieu. Veuillez remplir la formule à l'encre **noire** et la renvoyer au Centre d'accès aux soins communautaires dans les 10 jours.*

Last name/Nom de famille			Address/Adresse Number/N°, Street name/Nom de la rue		
Given name(s)/Prénom(s)					
Health No./Carte santé n°	Date of birth/Date de naissance YYYY/AAAA MM/MM DD/JJ	Sex/Sexe ☐M ☐F	City/Town/Ville	Province	Postal code/Code postal

Medical Diagnosis/Diagnostic médical

Diagnosis and date of onset:/Troubles diagnostiqués et date d'apparition :

Diagnosis discussed with applicant/ Diagnostic discuté avec le/la patient(e) ☐ yes/oui ⇨ by whom/qui en a discuté ☐ no/non ☐ not known/inconnu

Diagnosis discussed with family with applicant's consent/ Diagnostic discuté avec la famille ☐ yes/oui ⇨ by whom/qui en a discuté ☐ no/non ☐ not known/inconnu

History/Antécédemts

Brief health history *(include medical, surgical, family, social, psychiatric; attach medical report or consultation if available)*
Antécédents (en bref) *(y compris les renseignements d'ordre médical, chirurgical, social, psychiatrique, sur la famille ; veuillez joindre rapports médicaux ou de consultation si disponibles) :*

List any drug sensitivities, allergies, addictions/Énumérez toute sensibilité à certains médicaments, les allergies et les toxicomanies

Present condition *(include any behavioural, social, emotional concerns)*/État actuel *(y compris tout problème d'ordre comportemental, social ou émotionnel)*

Last name/Nom	Given name(s)/Prénom(s)	Health no./Carte Santé nº

Last 2 step Mantoux/Dernière intradermoréaction de Mantoux en 2 étapes

Date YYYY/AAAA MM/MM DD/JJ	Result/Résultat	Action taken/Mesure prise

Last chest X-ray/Dernière radiographie pulmonaire

Date YYYY/AAAA MM/MM DD/JJ	Result/Résultat	Action taken/Mesure prise

Last MRSA Screening//Dernier test de dépistage du SARM

Date YYYY/AAAA MM/MM DD/JJ	Result/Résultat	Action taken/Mesure prise

Last VRE Screening/Dernier test de dépistage des ERV

Date YYYY/AAAA MM/MM DD/JJ	Result/Résultat	Action taken/Mesure prise

Last Flu shot/Dernière vaccination antigrippale
Date YYYY/AAAA MM/MM DD/JJ

Pneumococcal vaccine/Vaccin antipneumococcique
Date YYYY/AAAA MM/MM DD/JJ

Prognosis/Pronostic

☐ improve/mieux ☐ deteriorate/se détériore
☐ remain stable/stable ☐ unknown/inconnu
☐ palliative/palliatif

Prognosis discussed with applicant/ Pronostic discuté avec le/la patient(e) by whom/qui en a discuté
☐ yes/oui ☐ no/non ☐ not known/inconnu

Prognosis discussed with family with applicant's consent/Pronostic discuté avec la famille avec le consentement de pa personne by whom/qui en a discuté
☐ yes/oui ☐ no/non ☐ not known/inconnu

Current medications and diet/Médicaments et régime actuels

Requires oxygen, blood gas count *(if available)*/A besoin d'oxygène, taux de gaz sanguin (si disponible)
☐ yes/oui ☐ no/non

☐ tank/réservoir ☐ nasal prongs/pinces nasales
☐ concentrator/concentrateur ☐ mask/masque

Rate/Débit

Frequency/Fréquence

Other special needs/Autres besoins particuliers
(e.g. colostomy, catheter, tube feeding, special diet)/ (p. ex. : colostomie, sonde, alimentation par sonde, régime particulier)

Has applicant been seen by other health care providers *(e.g. medical specialists, rehabilitation specialists, dieticians, social worker)? If so describe outcome:/* Est-ce que la patiente ou le patient a consulté d'autres fournisseurs de soins de santé *(p. ex. médecins spécialistes, spécialistes en réadaptation, diététistes, travailleurs sociaux)? Dans l'affirmative, quel a été le résultat :*

Current treatments required/Traitements en cours

Is family doctor aware that an application is being made for admission to a Long-Term Care facility/Le médecin de famille sait-il que le patient ou la patiente fait l'objet d'une demande d'admission dans un établissement de soins de longue durée ?
☐ yes/oui ☐ no/non
Name of family doctor//Nom du médecin de famille

Is family doctor willing to continue to provide care when the applicant has been admitted to a Long-Term Care facility/Est-ce que le médecin de famille est disposé à prodiguer des soins au patient ou à la patiente après son admission dans l'établissement de soins de longue durée ?
☐ yes/oui ☐ no/non ☐ unknown/ inconnu ☐ not applicable/ sans objet

Name of person completing the form/Nom de la personne qui remplit le rapport

Telephone no./Nº de téléphone

Address/Adresse
Number/Nº, Street name/Nom de la rue

City/Town/Ville

Province

Postal code/ Code postal

Signature/Signature

Discipline
☐ RN ☐ RN (EC) ☐ MD

Date YYYY/AAAA MM/MM DD/JJ

FUNCTIONAL ASSESSMENT FOR PLACEMENT

LAST NAME:_____ FIRST NAME:_____ HEALTH CARD#:_____

AMBULATION **Aids:** ☐ N/A ☐ Cane ☐ Walker ☐ Crutches ☐_____
☐ Wheelchair ☐ Self-Propelled ☐ Assisted ☐ Motorized _____

Assistance Required: ☐ On level ☐ One Person ☐ Two People
☐ To sit down in chair ☐Falls- Reason/Frequency _____
☐ Bedridden – Please explain _____

TRANSFER ☐ Independent ☐ Requires two person assistance
☐ Requires supervision ☐ Requires more than two persons or mechanical aid
☐ Requires one person assistance ☐ Cannot weight bear

LIMBS ☐ Normal Impaired Arm: ☐ Right ☐ Left ☐ Comment:_____
☐ Amputation Comment: _____ Impaired Leg: ☐ Right ☐ Left ☐ Comment:_____
☐ Independent with prosthesis No use of Arm: ☐ Right ☐ Left ☐ Comment:_____
☐ Needs Assistance with prosthesis No use of Leg: ☐ Right ☐ Left ☐ Comment:_____

BOWEL ☐ Full Control ☐ Retraining ☐ Occasionally Incontinent
☐ Routine Toileting to Maintain Control ☐ Incontinent ☐ Using Incontinent Product

BLADDER ☐ Full Control
☐ Routine Toileting to Maintain Control ☐ Occasionally Incontinent (specify) _____
☐ Incontinent:_____ ☐ Presently Using Condom
☐ Catheter: ☐ Indwelling_____ ☐ Will be removed prior to discharge
☐ Continuous Bladder Irrigation ☐ Retraining
☐ In & Out – Why? _____ ☐ Using incontinent product

OSTOMY
Ability to Care for Ostomy ☐N/A ☐ Yes (Type and Care Required) ☐ Independent ☐ Requires Supervision/ Assistance
☐ Total Care

DIALYSIS ☐ N/A ☐ Haemodialysis (Frequency/Days/Location) _____
☐ Peritoneal (Type/Frequency) _____ Facility _____

SKIN CONDITION ☐ **Footcare** ☐ Decubitus Ulcer / Open Sores
☐ Normal Description _____
☐ Incision Stage _____
☐ Rashes Size _____
☐ Burn Location _____
Prescribed Treatment _____ Improving ☐ Yes ☐ No

COGNITIVE FUNCTION ☐ Unimpaired ☐ Impaired Judgment ☐ Lacks Attention
Memory Loss: ☐ Recent ☐ Remote ☐ Forgetful: ☐ Personal Hygiene
☐ Electrical Devices
☐ Medication
Disoriented to: ☐ Time ☐ Person ☐ Place
Overall Impact on ADL: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Specify Recent Changes:

BEHAVIOURAL ☐ Cognitively Impaired but Socially Appropriate Behaviour
☐ Cooperative _____ * ☐ Resistive ☐ When_____ ☐ To Whom _____
* ☐ Demanding _____ *☐ Aggressive _____
* ☐ Disruptive _____
* ☐ Suicidal Ideation _____ *☐ Depressed _____
* ☐ Self Mutilation _____ _____
* ☐ Repetitive _____ ***Wanders:** ☐ Exit Seeking _____ ☐ Pacing_____
☐ Speech _____
☐ Movement_____ *Agitated: ☐ Day ☐ Night ☐ Sundowning _____
* ☐ Hoarding_____ *Abusive: ☐ Verbally ☐ Physically
☐ Generally ☐ Specifically_____
* ☐ Suspicion_____ ☐ Anxious _____
* ☐ Paranoia_____ ☐ Screams _____
☐ Sexual Disinhibition _____
☐ Behavioural Assessment Available * **Comprehensive behavioural assessment may be required**

LAST NAME:_____ FIRST NAME:_____ HEALTH CARD#: _____

SPEECH ☐ Adequate ☐ Aphasic/Dysarthric **TRANSLATOR USED**
☐ Language Barrier _____ ☐ Health Care Worker _____
Communicates ☐ By _____
☐ With Difficulty _____ ☐ Relative _____
☐ Unable (Specify) _____ ☐ Other (Specify) _____

VISION *(with aid, if worn)* ☐ Adequate ☐ Blind ☐ Glasses ☐ Cataracts: ☐ Operable ☐ Inoperable
☐ Other (Specify) _____

HEARING ☐ Adequate ☐ Impaired ☐ Deaf: ☐ Left ☐ Right ☐ Tinnitus
☐ Aids (Specify) _____

ABILITY TO EAT ☐ Independent ☐ Dependent
Requires Assistance: Approx. time required _____ ☐ Set up ☐ Cueing ☐ Supervision
☐ Difficulty Swallowing ☐ Swallowing Assessment Available ☐ Nasogastric Tube ☐ Gastrostomy Tube
☐ Difficulty Chewing Schedule/Type _____
Dentures: ☐ Full ☐ Partial _____
☐ Dietary Requirements _____

ABILITY TO DRESS ☐ Independent ☐ Reluctant ☐ Dependent ☐ Cueing
☐ Requires Supervision (Specify) _____
☐ Requires Assistance (Specify) _____

ABILITY TO BATHE OR WASH ☐ Independent ☐ Refuses ☐ Dependent
☐ Requires Supervision (Specify) _____
☐ Requires Assistance (Specify) _____

SLEEP ☐ Sleeps Most of the Night ☐ Currently Receiving Sedation (Specify) _____
☐ Noisy ☐ Has Difficulty Sleeping (Specify) _____

SAFETY REQUIREMENTS Restraints: Why? _____ When? _____
☐ Physical ☐ Chemical
☐ Bed Rails ☐ Geri Chair
☐ N/A ☐ Currently in Secured Unit

SPECIAL NEEDS ☐ Suction (Frequency) _____ ☐ Oxygen (Include Details on Health Report p.2)
☐ N/A ☐ Tracheostomy ☐ Ventilator
Precautions Required ☐ Other (Specify) _____ ☐ Glucometer Checks (Frequency) _____
☐ VRE ☐ MRSA ☐ OTHER _____

PERSONAL DATA Approx. Height_____ Approx. Weight_____ B/P Range____ Heart Rate____ Respiratory Rate____
Smoker ☐ No ☐ Yes: ☐ Supervision Required
Alcohol Abuse ☐ No ☐ Yes: ☐ Episodic ☐ Active
Drug Abuse ☐ No ☐ Yes: ☐ Episodic ☐ Active Substances Used _____
Allergies ☐ No ☐ Yes: (Specify) _____

Specify treatment of above_____

OVERALL CARE LEVEL ☐ Light ☐ Medium ☐ Heavy ☐ Wander Alert ☐ Secure Unit Required

Form Completed by (Please Print) _____

Professional Title _____ Telephone _____

Signature _____ Date_____

BEHAVIOURAL ASSESSMENT TOOL

Client Name (First, Last)		**Date of Birth**	Y Y Y Y M M D D
Health Card #			
CAF #		**Date Completed**	Y Y Y Y M M D D
Patient ID #			

This form is to be completed when the Functional Assessment component of the Long-Term Care Application indicates any other finding than "Cooperative" or "Cognitively Impaired but Socially Appropriate Behaviour" is checked off.

Please indicate the behaviour that most describes the client. Comment sections MUST include triggers, onset, frequency of occurrence, time of day and interventions required.

ALL SECTIONS MUST BE COMPLETED IN FULL

1. Wanders:

☐Behaviour not present
☐Wanders but does not attempt to leave immediate environment, returns to own room without assistance/ supervision
☐Wanders but does not attempt to leave immediate environment, but is unable to locate own room without assistance/ supervision
☐Wanders and will leave immediate environment if not prevented

Comments:

_____

_____

2. Hoarding / Rummaging:

☐ Behaviour not present
☐ Hoards food or medications or picks up objects which are lying around, but does not search others belongings
☐ Searches others belongings looking for food, medications or object

Comments:

_____

_____

3. Agitated Behaviour

☐ Behaviour not present
☐ Restless, cries out, paces and/or chatters in response to minor changes in routine
☐ Restless, cries out, paces and/or chatters in response to major changes in routine
☐ Restless, cries out, paces and/or chatters without stimulus

Comments:

_____

_____

Client Name: _____

4. Verbally Aggressive / Angry Behaviour:

- ☐ Behaviour not present
- ☐ Displays anger, or is verbally abusive in predictable situations, i.e. when provoked
- ☐ Occasionally angry or verbally aggressive with no apparent provocation
- ☐ Frequently angry or verbally aggressive without provocation

Comments:

_____

_____

5. Physically Aggressive / Angry Behaviour:

- ☐ Behaviour not present
- ☐ Displays anger, physically aggressive in predictable situations, i.e. when provoked
- ☐ Occasionally angry or physically aggressive with no apparent provocation
- ☐ Frequently angry or physically aggressive without provocation

Comments:

_____

_____

6. Suspicious Behaviour:

- ☐ Behaviour not present
- ☐ Occasionally suspicious of food or people
- ☐ Suspicious of most people/ food but behaviour does not disrupt daily routine
- ☐ Suspicious of most people/ food in environment to the extent that it interferes with daily routines, i.e. eating

Comments:

_____

_____

7. Indiscriminate Ingestion of Foreign Substances:

- ☐ Behaviour not present
- ☐ Occasionally ingests, eats foreign substances
- ☐ Ingests foreign substances/ objects. Requires frequent supervision

Comments:

_____

_____

8. Inappropriate Sexual Behaviour:

- ☐ Behaviour not present
- ☐ Occasionally exposes self, or makes inappropriate remarks or gestures
- ☐ Frequently exposes self or makes inappropriate remarks or gestures
- ☐ Occasionally touches others inappropriately
- ☐ Frequently touches others inappropriately

Comments:

_____

_____

Client Name: _____

9. Inappropriate Smoking:

- ☐ Behaviour not present
- ☐ Occasionally unsafe smoker
- ☐ Frequently unsafe smoker

Comments:

_____

_____

10. Alcohol and/ or Drug Abuse:

- ☐ Behaviour not present
- ☐ Behaviour present but not a problem
- ☐ Occasional problem causing danger to self only
- ☐ Occasional problem causing danger to self and others
- ☐ Frequent behaviour causing danger to self and/ or others

Comments:

_____

_____

11. Resists Treatment or Refuses Care:

- ☐ Behaviour not present
- ☐ Occasionally resists or refuses but can be persuaded to comply
- ☐ Occasionally resists or refuses and misses treatment as a result
- ☐ Frequently resists or refuses but eventually complies
- ☐ Frequently resists or refuses and cannot be persuaded to comply

Comments:

_____

_____

12. Acts Sad or Depressed

- ☐ Behaviour not present
- ☐ Exhibits behaviour but participates in activities without supervision
- ☐ Exhibits behaviour and needs supervision or encouragement to participate and complete activities
- ☐ Exhibits behaviour and refuses to participate or cooperate in activities

Comments:

_____

_____

13. Attention Seeking (Physical or Psychological Complaints):

- ☐ Behaviour not present
- ☐ Intermittently demands attention
- ☐ Frequently demands attention
- ☐ Constantly demands attention

Comments:

_____

_____

Client Name: _____

14. Suicidal Behaviour

☐ Behaviour not present
☐ Verbalizes ideas of suicide, no prior history of threats or attempts
☐ Verbalizes ideas of suicide, history of prior threats or attempts
☐ Verbalizes plans for suicide
☐ Has attempted suicide within the past year

Comments:
_____
_____

15. Anxious Behaviour

☐ Behaviour not present
☐ Exhibits anxious behaviour in predictable situations
☐ Occasionally exhibits anxious behaviour in unpredictable situations
☐ Frequently exhibits anxious behaviour

Comments:
_____
_____

16. Potential for injury to Self or Others

Presence of behaviour that places self or others at risk for psycho-social or physical injury and which requires intervention. Includes clients whose physical condition or tendency toward violence contributes to the risk. Intervention is aimed at reducing or removing risks.

☐ No intervention required
☐ General observation and intermittent intervention required less frequently than every hour
☐ Close observation and intermittent intervention required hourly or more often, but less than every hour
☐ Close and constant intervention required every 15 minutes or less

Comments:
_____
_____

17. Ineffective Coping

Presence of behaviour that reflects inability to deal appropriately with routine living situations or with individuals and which requires intervention. Intervention is aimed at altering ability to cope.

☐ No Intervention required
☐ Intervention required totalling less than 30 minutes over a 24- hour period
☐ Intervention required totalling from 30 minutes up to but not including 2 hours over a 24- hour period
☐ Intense intervention required totalling 2 hours or more over a 24- hour period

Comments:
_____
_____

Client Name: _____

General Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Form Completed By (Please Print)

_____ _____

Signature Date

_____

Key Additional Informant(s)

PATIENT TAKE-BACK AGREEMENT - Acute Care Hospital

To be returned with application

Attention: Dr. Morris Freedman, Director, Behavioural Neurology Unit
C/O Admission Office, Baycrest Hospital
Telephone: 416-785-2500, Ext. 2311
Fax: 416-785-2471

This agreement is between the Behavioural Neurology short-term inpatient unit and

_____

Referring Facility Name

This is to confirm that _____ will be accepted back
Print Patient Name
into our facility should he/she be unable to return home, or should a long-term care bed not be available at the time of discharge from Behavioural Neurology.

_____

Appropriate Hospital ohhDesignate (Name) Signature Title Date

X _____

Telephone Number Extension Date

PATIENT TAKE-BACK AGREEMENT – Long Term Care Facility

Facility Name: _____ Ext. _____

Nursing Station Telephone: _____ Ext. _____

Name of Patient: _____ **Room # - Floor/Unit**: _____

Facility Contact Person _____ Title _____

Tel: _____ Ext. _____ Fax: _____

Specify Patient Leave from your facility:

☐ 45-day Psychiatric Leave ☐ 21-day Medical Leave ☐ Extended Leave (specify time)

To be returned with application

To: Dr. Morris Freedman, Director, Behavioural Neurology Unit
C/O Admission Office, Baycrest Hospital
Telephone: 416-785-2500, Ext. 2311
Fax: 416-785-2471

This letter serves as our understanding and agreement that, upon discharge from the Behavioural Neurology Unit, we will accept the above-named patient back into our facility where a bed has been held for their return.

The patient's family/POA for Personal Care and Financial Property has been informed, understands and is in agreement with this arrangement.

_____

Print Name of Appropriate Facility Designate Signature Title

Dated: _____ Telephone _____ X ____