

**North Saskatchewan Dementia Assessment Outreach Team Referral Form**

**REFERRAL CRITERIA: (A) Criteria:** For persons with age-related degenerative dementia exhibiting responsive behaviours, related to a primary diagnosis of dementia, who is medically stable, and requiring enhanced behavioural support in their current care environment. Exclusionary criteria include delirium and a primary diagnosis of Acquired Brain Injury. **(B) Criteria:** Referral form must be accompanied by: **1)** a completed 7-Day Direct Observation System (DOS); **2)** Medication Administration record (MAR); **3)** PRN med sheet; **4)** Blood work (< 3 months) including CBC, Renal and Liver panel, TSH, B12, HgA1c, Blood glucose, Calcium, Urinalysis, Urine C&S (only if UTI guideline criteria has been met); **5)** most recent MDS report including Outcome Scales and CAP reports.

Client Information					
Last Name:		First Name:		Date of Referral: (dd/mm/yyyy) _____/_____/_____	
Date of Birth: (dd/mm/yyyy) _____/_____/_____		Age:	Health Card Number/MRN:		
<input type="checkbox"/> LTC/Acute:		Address:		Physician:	
<input type="checkbox"/> Community/Agency:		Address:		Physician:	
Health Region:		Telephone No.:		Fax No.:	
Marital Status:		<input type="checkbox"/> Single/Never married	<input type="checkbox"/> Common Law	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
		<input type="checkbox"/> Married	<input type="checkbox"/> Life partnered	<input type="checkbox"/> Divorced	<input type="checkbox"/> Unknown/Chose not to disclose
Treaty Status		<input type="checkbox"/> Status	<input type="checkbox"/> Non status	<input type="checkbox"/> Unknown/Choose not to disclose	
Reason for Referral					
What is the primary behavior of concern? What has changed?					
Physically Responsive	New	Existing	Physical/Non-Aggressive	New	Existing
Slapping	<input type="checkbox"/>	<input type="checkbox"/>	Pace, aimless wandering	<input type="checkbox"/>	<input type="checkbox"/>
Punching	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate dress or disrobing	<input type="checkbox"/>	<input type="checkbox"/>
Grabbing onto people	<input type="checkbox"/>	<input type="checkbox"/>	Trying to leave/exit seeking	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Intentional falling	<input type="checkbox"/>	<input type="checkbox"/>
Throwing things	<input type="checkbox"/>	<input type="checkbox"/>	Eating/drinking inappropriate substance	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	Hiding things	<input type="checkbox"/>	<input type="checkbox"/>
Scratching	<input type="checkbox"/>	<input type="checkbox"/>	Collecting things	<input type="checkbox"/>	<input type="checkbox"/>
Spitting	<input type="checkbox"/>	<input type="checkbox"/>	Performing repetitive mannerisms	<input type="checkbox"/>	<input type="checkbox"/>
Pinching	<input type="checkbox"/>	<input type="checkbox"/>	General restlessness	<input type="checkbox"/>	<input type="checkbox"/>
Tearing things or destroying property	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Engaging in sexualized behaviour	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Verbally Responsive	New	Existing	Verbal / Non-Aggressive	New	Existing
Screaming	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive sentences or questions	<input type="checkbox"/>	<input type="checkbox"/>
Cursing	<input type="checkbox"/>	<input type="checkbox"/>	Strange noises (weird laughter, crying, moaning)	<input type="checkbox"/>	<input type="checkbox"/>
Making threats	<input type="checkbox"/>	<input type="checkbox"/>	Complaining	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Sexualized behaviour	<input type="checkbox"/>	<input type="checkbox"/>	Constant unwarranted requests for attention or help	<input type="checkbox"/>	<input type="checkbox"/>
Name Calling	<input type="checkbox"/>	<input type="checkbox"/>			
Support System					
Living Arrangements (include length of time): <input type="checkbox"/> Alone _____ <input type="checkbox"/> Family _____ <input type="checkbox"/> PCH _____ <input type="checkbox"/> LTC _____ <input type="checkbox"/> Other _____					
Has the family/Substitute Decision Maker (SDM) consented to the referral: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Advanced Care Directives: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Attached					
Treatment Decisions Made By (check one):					
<input type="checkbox"/> Self <input type="checkbox"/> Proxy/POA <input type="checkbox"/> SDM/Family Name: _____ Contact #: _____					
Formal Supports (Name/Phone):	Relationship		Informal Supports (Name/Phone)	Relationship	
Medical History / Diagnosis					
Dementia Diagnosis: (and date if known)					
<input type="checkbox"/> Alzheimer's _____ <input type="checkbox"/> Vascular _____ <input type="checkbox"/> Frontal Lobe _____ <input type="checkbox"/> Lewy-Body _____					
<input type="checkbox"/> Other (Explain) _____					
Have they been reviewed by a specialist (include name): _____					
<input type="checkbox"/> Psychiatry <input type="checkbox"/> Neurology <input type="checkbox"/> Geriatrician <input type="checkbox"/> Other (Explain) _____ <input type="checkbox"/> Consult Attached					
Who made the diagnosis of dementia:					
<input type="checkbox"/> Psychiatry <input type="checkbox"/> Neurology <input type="checkbox"/> Family Physician <input type="checkbox"/> Other (Explain) _____ <input type="checkbox"/> Consult Attached					

**Delirium History:** (list dates and causes)

**Screening for Delirium:**

- Acute change in Mental Status and functioning
- Behaviour is fluctuating during the day
- Inattention- easily distracted and decreased ability to focus
- Disorganized Thinking or incoherent, such as, rambling conversation, unclear or illogical flow of ideas, switching topics
- Altered Level of Consciousness     Easily startled     Lethargic     Difficult to arouse     Coma

**Medical History / Diagnosis:**

**Mental Health History:**

- Depression     Anxiety     ETOH Abuse     OTC/R<sub>x</sub>/Illicit Drug Abuse
- Bipolar     Schizophrenia     Schizoaffective
- Acquired Brain Injury (date): \_\_\_\_\_
- Intellectually Disabled
- Other: \_\_\_\_\_

**Hospitalizations**

**Vitals /Current Medical Status**

Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Resp: \_\_\_\_\_ SPO<sub>2</sub>: \_\_\_\_\_ Temp: \_\_\_\_\_ Blood Glucose: \_\_\_\_\_ mmol/L

Deviation from baseline?     Yes     No    If yes, please explain: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gain/Loss \_\_\_\_\_ lb/kg    Since (date): \_\_\_\_\_

MRSA     VRE     ESBL     C.Diff.     Other: \_\_\_\_\_

Recent Infections (Diagnosis & date) \_\_\_\_\_

Falls (past year): \_\_\_\_\_

Hospitalizations (in past year): \_\_\_\_\_

Allergies (list): \_\_\_\_\_

**Risk Assessment** Number of incident reports in the    Past week \_\_\_\_\_    Past month \_\_\_\_\_

Based on your current knowledge of the patient, please select the most appropriate level of risk:	High (H) Very likely harm will occur / re-occur if preventative measures are not put in place to reduce elevated risks.	Moderate (M) Potential harm will occur/re-occur if risks are not identified, managed and timely supports are not implemented.	Low (L) Unlikely harm will occur. Supports in place to focus on preventing escalation, reducing vulnerability and strengthening capacities.
<input type="checkbox"/> <b>Roaming/Wandering</b> <input type="checkbox"/> No Known Concerns <input type="checkbox"/> Pacing <input type="checkbox"/> Exits <input type="checkbox"/> Rooms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <b>Imminent Physical Risk</b> <input type="checkbox"/> No Known Concerns <input type="checkbox"/> Frailty (Delirium) <input type="checkbox"/> Falls <input type="checkbox"/> Fires <input type="checkbox"/> Firearms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> No Known Concerns <input type="checkbox"/> Thoughts <input type="checkbox"/> Plan <input type="checkbox"/> Action <input type="checkbox"/> History	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <b>Risk of Harm</b> (specify who) <input type="checkbox"/> No Known Concerns <input type="checkbox"/> Self <input type="checkbox"/> Residents <input type="checkbox"/> Staff <input type="checkbox"/> Visitors <input type="checkbox"/> Family <input type="checkbox"/> History of Violence <input type="checkbox"/> Substance use / abuse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <b>Self-Neglect</b> <input type="checkbox"/> No Known Concerns <input type="checkbox"/> Unsafe Driving <input type="checkbox"/> Substance Use <input type="checkbox"/> Medications <input type="checkbox"/> ADL's / IADL's	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

List each intervention tried. How long? What was the outcome?     See Attached

Do you have other pertinent information not captured elsewhere?     See Attached

Referral completed by (include designation if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Position: \_\_\_\_\_ Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email: \_\_\_\_\_