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Attach a File: Instructions

DA Team: 306-655-3844
Fax: 306-655-3934
*Important: If faxing referral, please email to let us know a referral is being faxed: dementia.assessment@saskatoonhealthregion.ca

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:**

☐ **LTC/Acute:** **Address:** **Physician:**

☐ **Community/Agency:** **Address:** **Physician:**

Health Region: **Telephone No.:** **Fax No.:**

Marital Status: ☐ Single/Never married ☐ Common Law ☐ Separated ☐ Widowed ☐ Married ☐ Life partnered ☐ Divorced ☐ Unknown/Chose not to disclose

Treaty Status ☐ Status ☐ Non status ☐ 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	☐	☐	Pace, aimless wandering	☐	☐
Punching	☐	☐	Inappropriate dress or disrobing	☐	☐
Grabbing onto people	☐	☐	Trying to leave/exit seeking	☐	☐
Pushing	☐	☐	Intentional falling	☐	☐
Throwing things	☐	☐	Eating/drinking inappropriate substance	☐	☐
Biting	☐	☐	Hiding things	☐	☐
Scratching	☐	☐	Collecting things	☐	☐
Spitting	☐	☐	Performing repetitive mannerisms	☐	☐
Pinching	☐	☐	General restlessness	☐	☐
Tearing things or destroying property	☐	☐			
Engaging in sexualized behaviour	☐	☐			
Verbally Responsive	**New**	**Existing**	**Verbal / Non-Aggressive**	**New**	**Existing**
Screaming	☐	☐	Repetitive sentences or questions	☐	☐
Cursing	☐	☐	Strange noises (weird laughter, crying, moaning)	☐	☐
Making threats	☐	☐	Complaining	☐	☐
Verbal Sexualized behaviour	☐	☐	Constant unwarranted requests for attention or help	☐	☐
Name Calling	☐	☐			

Support System

Living Arrangements (include length of time): ☐ Alone_____ ☐ Family_____ ☐ PCH_____ ☐ LTC_____ ☐ Other_____

Has the family/Substitute Decision Maker (SDM) consented to the referral: ☐ Yes ☐ No

Advanced Care Directives: ☐ Yes ☐ No ☐ Attached

Treatment Decisions Made By (check one):

☐ Self ☐ Proxy/POA ☐ SDM/Family Name: _____ Contact #: _____

Formal Supports (Name/Phone):	**Relationship**	**Informal Supports (Name/Phone)**	**Relationship**

Medical History / Diagnosis

Dementia Diagnosis: (and date if known)

☐ Alzheimer's _____ ☐ Vascular _____ ☐ Frontal Lobe _____ ☐ Lewy-Body _____

☐ Other (Explain)_____

Have they been reviewed by a specialist (include name): _____

☐ Psychiatry ☐ Neurology ☐ Geriatrician ☐ Other (Explain) _____ ☐ Consult Attached

Who made the diagnosis of dementia:

☐ Psychiatry ☐ Neurology ☐ Family Physician ☐ Other (Explain) _____ ☐ 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:

Hospitalizations

_____

Mental Health History:

☐ Depression ☐ Anxiety ☐ ETOH Abuse ☐ OTC/R_x/Illicit Drug Abuse
☐ Bipolar ☐ Schizophrenia ☐ Schizoaffective
☐ Acquired Brain Injury (date): _____
☐ Intellectually Disabled
☐ Other: _____

Vitals /Current Medical Status

Pulse: _____ Blood Pressure: _____/_____ Resp: _____ SPO_2: _____ 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.
☐ **Roaming/Wandering** ☐ No Known Concerns ☐ Pacing ☐ Exits ☐ Rooms	☐	☐	☐
☐ **Imminent Physical Risk** ☐ No Known Concerns ☐ Frailty (Delirium) ☐ Falls ☐ Fires ☐ Firearms	☐	☐	☐
☐ **Suicide** ☐ No Known Concerns ☐ Thoughts ☐ Plan ☐ Action ☐ History	☐	☐	☐
☐ **Risk of Harm** (specify who) ☐ No Known Concerns ☐ Self ☐ Residents ☐ Staff ☐ Visitors ☐ Family ☐ History of Violence ☐ Substance use / abuse	☐	☐	☐
☐ **Self-Neglect** ☐ No Known Concerns ☐ Unsafe Driving ☐ Substance Use ☐ Medications ☐ ADL's / IADL's	☐	☐	☐

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:		