HOME AND COMMUNITY CARE SUPPORT SERVICES
Toronto Central

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Centre-Toronto

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
Toronto Region | Région de Toronto

Baycrest

Behaviour Support Outreach Team

Name of Client: Last Name _____ First Name _____ Client identifies their gender as: _____

Address: _____ **ON**

Phone #: _____ **Marital Status:** _____

Health Card #: _____ **HCN version** _____ **DOB:** _____ YY/MM/DD

SDM/POA Name: _____ **Relationship:** _____ **Phone #:** _____

Is client/substitute decision maker agreeable to referral? ☐ **Yes** ☐ **No**

Relevant Medical Diagnoses:

- ☐ Substance Misuse
- ☐ Hx of ABI
- ☐ Huntington's Disease
- ☐ Dementia Diagnosis Please specify
- ☐ Neurological Disorder Please specify
- ☐ Hx of Mental Health Issues Please specify

Specialists/Teams involved:

- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Neurology
- Other:

REASON FOR REFERRAL

- ☐ **Agitated Behaviour** - state of restlessness, anxiety, inability to settle
- ☐ **Delusions** – Fixed, false beliefs
- ☐ **Hallucinations** – visual, auditory, gustatory, tactile, olfactory
- ☐ **Hoarding –** collecting objects and refusing to part with them
- ☐ **Oral intake of non-edible objects and substances**
- ☐ **Low Mood/Depressed** (Crying, tearfulness, reduced social interaction, loss of interest, loss of pleasure)
- ☐ **Physically Responsive Behaviour** (spitting, kicking, grabbing, pushing etc.)
- ☐ **Resists Care** (e.g. resists taking medications/injections)
- ☐ **Rummaging** – Touching and handling objects with no obvious purpose
- ☐ **Sexual Behaviour** – unwanted verbal or physical sexual advances towards others.
- ☐ **Substance Use/Misuse/Abuse** – Alcohol
- ☐ **Substance Use/Misuse/Abuse** – Drug
- ☐ **Substance Use** - Smoking
- ☐ **Suicidal Behaviour**
- ☐ **Verbally Responsive Behaviour** (yelling, screaming, threatening, cursing, etc.)
- ☐ **Wanders –** exit-seeking

Description/Comments *(main concern for referral and the responsive behavior)*

Date of the Referral: _____ (YY/MM/DD)

Name of the Referrer (***please print***)**:** Last Name First Name

Professional Designation (***please print***)**:** MD ☐ NP ☐ RN ☐ GEM Nurse ☐ SW ☐ Other ☐ **Phone or Email:**

Please attach the following documentation: GEM and/or SW consult notes (if available); ED face sheet/physician notes etc.

FAX the completed referral form to the Home and Community Care Support Services Toronto Central BSOT team at 416-217-1443 or email BSOT@tc.lhins.on.ca

Catchment area for Home Visits: Islington Ave. to Warden Ave., the Lake to Hwy 401/Eglinton.

AND/OR CALL the Toronto Seniors Helpline (TSH) at 416-217-2077 to access Crisis Outreach Service for Seniors (COSS) if needed

TSH Hours are Monday-Friday 9:00am-8:00pm / Saturday-Sunday and Holidays 10:00am-6:00pm

Ontario