Joint STAT Centre & MSJ One South Referral Form

Please select one:

☐ Short Term Assessment and Treatment (STAT) Centre Inpatient Unit Please fax referral to: *604-827-0995*

☐ Short Term Assessment and Treatment (STAT) Centre Medical Day Program Please fax referral to: *604-827-0995*

☐ One South Geriatric Psychiatry Unit Please fax referral to: *604-877-8157*

Please see Appendix 1 for program descriptions, goals of care, inclusion/exclusion criteria

GENERAL INFORMATION		
Client Name:	DOB (D/M/Y):	☐ Male ☐ Female ☐ Other Gender Identity
Home Address:		Postal Code:
Care Facility (if applicable):		
Client Height:	Client Weight:	
Home/Facility Telephone:	PHN:	
Does the client identify as Indigenous? ☐ Yes ☐ No	MSP Active ☐ Yes ☐ No	
Referring Clinician:	Phone:	
Referring Physician/Psychiatrist:	Phone:	
Family Physician:	Phone:	Fax:
Primary Family Contact: Relationship:	Phone:	
Is the Client, Family or Physician/Psychiatrist aware of the Referral? ☐Yes ☐No If NO, please explain:		
Community health services involved in care (level of home supports, caregivers): Is client known to: Home Health ☐Yes ☐No Contact:_____ Continuing Care ☐Yes ☐No Contact:_____ Mental Health Team ☐Yes ☐No Contact:_____ Name of Team:_____	What is the anticipated disposition? ☐Home alone ☐Home with family/caregivers ☐Home with home supports ☐Assisted Living ☐Long Term Care ☐Other:_____	
DISPOSITION AGREEMENT		
Is this person able to return to their home/facility in which they currently reside? ☐Yes ☐No ☐Unknown If NO, please explain: Who has been involved in this decision?		
REFERRAL CHECKLIST		
Please provide: ☐Previous psychiatric and medical consultations and recent assessments ☐Most recent Medication Administration Record ☐Most recent Medication Allergies Record ☐All legal Documents for Financial and/or Health Care decision making	☐Recent relevant investigations ☐Level of Intervention (if known) ☐Any pertinent Mental Health Act forms ☐SIN (if known):	

PSYCHIATRIC STATUS/GOALS OF REFERRAL

Note: For STAT Centre Referrals, please indicate N/A if applicable

Reason for referral:

Cognitive Impairment: ☐Mild ☐Moderate ☐Severe

Cognitive Screenings: Name of Screener	Date Performed	Test Result

Psychiatric Diagnosis and History: *(Please elaborate on recent psychiatric & behavioural history – including rating scales)*

Is substance use an active issue?

Please identify as specifically as possible the PSYCHIATRIC GOALS OF ADMISSION:

RISK

☐ Wandering	☐ Verbal Aggression	☐ Suicidal Ideation
☐ Elopement	☐ Physical Aggression	☐ Self-Harm
☐ Falls	☐ Intrusive Sexual Behaviour	☐ Self Neglect
☐ Fire	☐ Homicidal Ideation	

CURRENT FUNCTIONAL STATUS

Bathing
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____

Dressing
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____

Eating
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____

Continence-Bladder
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____

Continence-Bowel
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____

Medication Management
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____

Transfers
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____
Lift: _____

Mobility
☐ Independent ☐ Supervision ☐ Assistance # of assistants: _____ Comments: _____
Describe aid: _____

Communication (i.e. Vision, hearing) Assisted devices: _____

Language Barrier: ☐Yes ☐No If yes, language spoken: _____

Sleep Patterns:
☐Sleeps all/most of the night without medications
☐Sleeps all/most of the night with medications
☐Disrupted

MEDICAL & FUNCTIONAL GOALS OF REFERRAL

Medical/Surgical Diagnoses and History:

Precautions: ☐MRSA ☐VRE ☐HEP B ☐HEP C ☐TB ☐HIV

Please identify as specifically as possible the MEDICAL GOALS OF ADMISSION (when applicable):

Please identify as specifically as possible the FUNCTIONAL GOALS OF ADMISSION:

PSYCHOSOCIAL INFORMATION

Please identify any family issues or pertinent social history:

Please list any other community supports *(i.e. Spiritual care, church, support groups, activities, etc.)*:

Please identify any known or suspected AGA issues:

Finances:
☐Independent ☐Capable ☐Not Capable ☐Needs further Assessment

☐Committee ☐Statutory Property Guardianship ☐POA ☐Rep 7 ☐Pension Trusteeship ☐Banking POA/Joint Bank Acct
☐ Informal Management

Name: _____ Relationship:_____ Contact Details:_____

Health Care Decision Making:
☐Independent ☐Temporary SDM ☐Rep 9 ☐Committee ☐Needs further Assessment

Name: _____ Relationship:_____ Contact Details:_____

Please comment on URGENCY & requested admission period?	Do you anticipate certification under the Mental Health Act? ☐Yes ☐No Is the patient being referred under Extended Leave? ☐Yes ☐No Date expiry of Form:_____

INTERVENTIONS

Pharmacological and non-pharmacological interventions attempted

Current Safety Interventions:

Safety Interventions	Date Last Used	Frequency	Details
Seclusion			
Security			
Restraints			
Wander guard			
Constant Care			
Other Alarms			

Comments:

FOR TEAM DISPOSITION ONLY

☐Date Referral Reviewed by CNL and/or Team:_____
☐Complete Referral ☐Incomplete Referral Date Referral source notified:_____

☐Referral Meets Criteria & Placed on Waitlist: Date:_____
☐Referral Does Not Meet Criteria (Declined) : Date:_____

Other Notes:

Appendix 1. Infographic of Older Adult* Specialty Inpatient MHSU Care

**Primarily people over age 65; those under the age of 65 years are reviewed on case by case basis*

Program	Goals of Care	Inclusion Criteria	Exclusion Criteria
Sub-Acute *Geriatric Unit*			
Short Term Assessment and Treatment (STAT) Centre ***LOS: 6-8 weeks*** *Location: UBC Hospital, Koerner Pavilion* *Beds: 16*	**Maximize level of functioning and independence for client's returning home**, in keeping with the "Home is best" philosophy Facilitate transition to LTC for clients admitted from community deemed unable to return home	Older adults with: A) Health changes that interfere with functioning and independence B) Complex medical, psychological, and/or social problems requiring an interdisciplinary team of geriatric specialists C) An assessment of "failure to thrive" in community *Residency Requirement: Vancouver CoC*	Older adults: A) With acute medical or psychiatric care needs B) Currently in LTC C) Whose health status cannot be changed with further assessment and treatment D) Whose primary issue is disposition planning
Acute *Geriatric Psychiatry Unit*			
One South Geriatric Psychiatry Unit ***LOS: 1-6 weeks*** *Location: Mount St Joseph Hospital, One South* *Beds: 16*	**To assess, treat and stabilize Acute Geri Psych patients** before discharging them to community (home, LTC) or referring to Tertiary Older Adult Mental Health	Older adults with: A) Late onset mood, psychotic and/or severe anxiety disorders B) A history of serious mental illness complicated by age-related medical frailty C) Moderate to severe major neurocognitive impairment such as behavioural and psychological symptoms associated with dementia (BPSD) D) Serious risk of harm to themselves or others in their current environment and requiring 24/7 care (as assessed by their community care providers/geriatric services) *Residency Requirement: Vancouver CoC*	Older adults with: A) A primary medical diagnosis, traumatic brain injury or substance use disorder B) A cognitive impairment or psychiatric disorder that is stable, whose primary issue is disposition planning C) An ALC designation awaiting placement in community, LTC or tertiary mental health
Tertiary *Geriatric Psychiatry Assessment & Stabilization Units* **For Tertiary referrals, please complete online CAD form:** https://one.vch.ca/dept-project/Regional-MHSU/Documents/TMHA-Older_Adult.pdf			
Willow Tertiary Mental Health Older Adult Assessment and Treatment Unit ***LOS: 3-6 months*** *Location: Willow Pavilion, 5th Floor* *Beds: 19* Parkview Tertiary Mental Health Older Adult Intensive Support ***LOS: 6-8 months*** *Location: Parkview at Youville Residence* *Beds: 32*	Willow To provide comprehensive assessment, diagnostic clarification, treatment and rehabilitation. Parkview To provide comprehensive treatment and stabilization Willow & Parkview To create individualized care plans that can be implemented in alternate levels of care to optimize functioning and quality of life.	Willow Older adults with: Serious mental illness complicated by age-related medical frailty ***OR*** Severe behavioural and psychological symptoms of dementia who require a secure treatment setting **& on-site security** Parkview Older adults with severe behavioural and psychological symptoms of dementia who require a secure, longer-term treatment setting. Willow & Parkview May have comorbid chronic medical conditions *Residency Requirement: Regional VCH catchment area (Vancouver, Coastal & Richmond CoC's)*	Willow & Parkview Older adults with: A) Acute medical needs typically treated in an acute care setting B) A primary medical diagnosis, traumatic brain injury or substance use disorder C) A cognitive impairment or psychiatric disorder that is stable, whose primary issue is disposition planning D) An ALC designation awaiting placement in community including LTC