BRODIE
Community & Residential Services

Referral Package – Day Program

Date of Referral:	Surname:	Given name(s) Other:
Date of Birth: Age:	Gender:	Preferred Language:
Marital status:	Health Card Number:	Religion:
Address: Type of residence i.e. family home, group home, nursing home etc.	Phone Number:	Diagnosis:
Next of Kin: Phone:	Substitute decision maker:	Family physician:
Referral Source:	Contact person:	Consent obtained for Referral Yes ☐ No☐
Reason for Referral / Presenting problems:		
Medical History: Immunizations up to date: Yes ☐ No ☐ (copy received Yes ☐ No ☐) Date of most recent medical exam:		
Current psychiatric presentation if applicable (please be specific regarding signs/symptoms/behaviours):		
Current medications (or attach current MARS): Self Administered ☐ Staff Administered ☐		
Substance use:		
Legal involvement:		
Education / Work history (including learning disorders)		

List any individuals or agencies that are currently providing community support/case management to the client. Please identify the individual's primary worker with an asterisk (*)

Name of individual/agency	Contact Person	Telephone	Services Provided

Please rate the following behavioural concerns 1 = always, 2 = sometimes, 3 = never

BEHAVIOUR	Rate	BEHAVIOUR	Rate	BEHAVIOUR	Rate
Elopement		Screaming		Impulsive	
Forgetful		Scratching		Stealing	
Pacing		Kicking		Verbal Aggression	
Repetitive sentences/questions		Biting		Low insight	
Making strange noises		Pushing		Resistance to care	
Repetitious mannerisms		Throwing		Hurting self	
Attention seeking		Hitting		Hurting others	
Poor motivation		Spitting		Complaining	
Sexual advances / Behaviour		Property destruction		General restlessness	
Exposing self		Hiding things		Crying	
Isolates self		Hallucinations		Suicidal ideation	
Hoarding		Negative		Other	

Are there predicable or identified antecedents/triggers to the above behavioural concerns? Yes ☐ No ☐
If Yes, Please
Describe:_____
_____
_____
_____
_____
_____

Please indicate the clients functioning level for the following activities of daily living

	Check Column			
	Independent	Min. Assist	Moderate / total care	Comments
Dressing				
Shower/Bath				
Feeding				
Toileting				
Urinary	Continent	Occasional	Incontinent	
Bowel	Continent	Occasional	Incontinent	
Mobility	Ambulatory	Walker, cane	W/ch, Geri chair	
Transfer		1 person assist	2 person assist	Lift
Teeth	Own	Dentures: Upper Lower Both		

Hearing:	Eyesight:
Cognition: No impairment ☐ Can't locate room ☐ Can't recognize family ☐	
Communication: good ☐ fair ☐ poor ☐ none ☐ Can't follow instruction ☐	

Please check the following programs/activities that you would be interested in:

☐ Arts and Crafts / Visual Arts	☐ Horticulture Therapy / Gardening	☐ Math and Budgeting
☐ Cooking and Baking	☐ Aromatherapy	☐ Literacy and Literature
☐ Pet Therapy	☐ Intergenerational Activities	☐ Seasonal Events / Themed Events
☐ Music Therapy	☐ Positive Peer Relationships	☐ Self Esteem Building
☐ Cultural Activities	☐ News & Views / World Events	☐ Self Care Skills Development
☐ Exercise Therapy	☐ Cognitive Exercises	☐ Life Skills Development
☐ Anger Management	☐ Individualized Program Plans	☐ Field Trips

Additional comments or pertinent information:

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_____

_____

_____

_____

_____

Please email/mail or fax this referral package to:

Intake - BCRS
633 Albert Street
Oshawa, ON L1H 4T4
info@brodiecrs.com
Phone - (905) 240-2437
Fax – (905) 240-3437

The referring agency / person will be notified about the acceptance or rejection of the referral within 14 days of the date the referral was received. A reason for the decision will be given at that time.

Thank You for choosing BRODIE Community and Residential Services Inc.