BRODIE
Community & Residential Services Inc.

Referral Package – Day Program

Date of Referral:	Surname:	Given name(s) Other:
Date of Birth: Age:	Gender:	Preferred Language:
Marital status:	Health Card Number:	Allergies:
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): Psychiatrist:		
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:

_____
_____
_____
_____
_____

Please email fax or mail this referral package to:

Intake – BCRS Inc.
DAY PROGRAM
1255 Terwillegar Ave. UNIT 9
Oshawa, ON L1J 7A4

cheryl@brodiecrs.com
fax to (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.