

## Geriatric Assessment and Behavioural Unit (GABU) External Acute Care

Please send completed referral to GABU via 705-876-5837 or email: GABUfax@prhc.on.ca

Please confirm referral has been received by contacting GABU Coordinator: 705-743-2121 x. 4303

### Please note:

1. GABU referral is considered **incomplete** without “**GABU Admission Requirements**” as listed below.
2. GABU may request additional diagnostics, assessments or collateral information to determine eligibility for admission.
3. Reversible cause to behaviours explored or managed e.g. urinary retention (PVR's, TOV), constipation (abdominal x-ray), pain management.

### GABU PATIENT QUALIFICATIONS

- High-risk seniors, generally 65 years of age and older with an age-related established dementia diagnosis
- Medically stable with acute delirium ruled out as cause of behaviours
- Reversible causes to behaviours investigated, with attempted management
- Capacity is established prior to referral
- Mental health forms are to be evaluated prior to a GABU assessment/admission

### GABU ADMISSION REQUIREMENTS

- ☐ Lab results within one month: CBC, electrolytes, Ca, Alb, Mg, B12, creatinine, eGFR, B12, TSH, A1C (if diabetic)
- ☐ Urinalysis and urine culture within one month
- ☐ Medically stable
- ☐ Power of attorney documentation (if applicable)
- ☐ Signed consent for treatment
- ☐ Signed reciprocating agreement
- ☐ Delirium screening (CAM or I WATCH DEATH)
- ☐ Current medication administration record
- ☐ Behavioural notes, “ABC” notes

All above documents are required for referral review. If an item is unable to be obtained, please explain why:

### Supportive/Elective Documents

- Behavioural care plan
- Recent DOS (within 14 days)
- BSO consult or dates: \_\_\_\_\_
- Cornell scale for depression
- Pain assessments
- Geriatric depression scale
- Geriatric, Baycrest Virtual Behavioural Medicine notes or dates
- Relevant CXR, x-ray, CT or MRIs
- Cognitive testing (MMSE)

Referrals with Epic, please list documents dates:

### Simultaneous Referrals Being Placed:

- ☐ Ontario Shores   ☐ PASE   ☐ GAIN   ☐ Baycrest Virtual Behavioural Medicine   ☐ Not applicable

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**Patient Information**

|                                                                                                  |                                 |                                                                                |
|--------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------|
| Name:                                                                                            |                                 | Date of Birth (DD/MM/YYYY):                                                    |
| Gender: <input type="checkbox"/> Male                                                            | <input type="checkbox"/> Female | <input type="checkbox"/> Non-binary                                            |
| OHIP #:                                                                                          |                                 |                                                                                |
| Allergies:                                                                                       |                                 |                                                                                |
| Address:                                                                                         |                                 |                                                                                |
| Language:                                                                                        |                                 | Interpreter required: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Is the patient developmentally delayed: <input type="checkbox"/> YES <input type="checkbox"/> NO |                                 |                                                                                |

**Nurse Practitioner/Physician Providing Request for GABU application:** \_\_\_\_\_

**Referring source name and contact:**

\_\_\_\_\_

This contact can be used for continued coordination of program status, conferences, reparations and discharge planning.

Dementia Diagnosis (Please include date and who diagnosed, as applicable):

Referral Reason (behavioural presentations, onset, impact on daily functioning, ect.):

Past Psychotropic Medication Trials:

Past Psychiatric and Medical History:

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**Patient Function**

|                                   |                                                                                                                   |                                                                                            |                                                                            |                                           |
|-----------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------|
| <b>Ambulation:</b>                | <input type="checkbox"/> Independent<br><input type="checkbox"/> 1 person assist                                  | <input type="checkbox"/> Modified independence<br><input type="checkbox"/> 2 person assist | <input type="checkbox"/> Supervision<br><input type="checkbox"/> Dependent | <input type="checkbox"/> Does not perform |
| <b>Gait Aid:</b>                  | <input type="checkbox"/> Cane                                                                                     | <input type="checkbox"/> Walker (2ww or 4ww)                                               | <input type="checkbox"/> Wheelchair                                        | <input type="checkbox"/> NA               |
| <b>Transfer Status:</b>           | <input type="checkbox"/> Independent<br><input type="checkbox"/> 1 person assist                                  | <input type="checkbox"/> Modified independence<br><input type="checkbox"/> 2 person assist | <input type="checkbox"/> Supervision<br><input type="checkbox"/> Dependent | <input type="checkbox"/> Mechanical lift  |
| <b>Feeding Assistance:</b>        | <input type="checkbox"/> Independent                                                                              | <input type="checkbox"/> Independent after set up                                          | <input type="checkbox"/> Needs assistance, dependent                       |                                           |
| <b>Diet Order:</b>                |                                                                                                                   |                                                                                            |                                                                            |                                           |
| <b>Medication Administration:</b> | <input type="checkbox"/> Whole <input type="checkbox"/> Crushed                                                   |                                                                                            |                                                                            |                                           |
| <b>Dressing Assistance:</b>       | <input type="checkbox"/> Independent<br><input type="checkbox"/> 1 person assist                                  | <input type="checkbox"/> Modified independence<br><input type="checkbox"/> 2 person assist | <input type="checkbox"/> Supervision<br><input type="checkbox"/> Dependent |                                           |
| <b>Bathing Assistance:</b>        | <input type="checkbox"/> Independent<br><input type="checkbox"/> 1 person assist                                  | <input type="checkbox"/> Modified independence<br><input type="checkbox"/> 2 person assist | <input type="checkbox"/> Supervision<br><input type="checkbox"/> Dependent |                                           |
| <b>Toileting Assistance:</b>      | <input type="checkbox"/> Independent<br><input type="checkbox"/> 1 person assist                                  | <input type="checkbox"/> Modified independence<br><input type="checkbox"/> 2 person assist | <input type="checkbox"/> Supervision<br><input type="checkbox"/> Dependent | <input type="checkbox"/> Does not perform |
| <b>Bladder Continence:</b>        | <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Mixed continence |                                                                                            |                                                                            |                                           |
| <b>Bowel Continence:</b>          | <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Mixed continence |                                                                                            |                                                                            |                                           |
| <b>Patient Uses:</b>              | <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Dentures, other:  |                                                                                            |                                                                            |                                           |

**Current Living Arrangement**

|                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Lives alone <input type="checkbox"/> With partner/spouse <input type="checkbox"/> With children <input type="checkbox"/> Other: |
| Community Servies [ADP, PSW supports hours per day]:                                                                                                     |

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## Responsive Behaviours

Please check all that apply.

| Presentation                 | Behavioural Expression                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Verbal Expressions           | <input type="checkbox"/> Crying <input type="checkbox"/> Grunting <input type="checkbox"/> Humming <input type="checkbox"/> Moaning <input type="checkbox"/> Questions<br><input type="checkbox"/> Requests <input type="checkbox"/> Sighing <input type="checkbox"/> Words <input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                      |
| Motor Expressions            | <input type="checkbox"/> Banging <input type="checkbox"/> Collecting/Hoarding <input type="checkbox"/> Disrobing<br><input type="checkbox"/> Exploring/Searching <input type="checkbox"/> Fidgeting <input type="checkbox"/> Grinding Teeth<br><input type="checkbox"/> Pacing <input type="checkbox"/> Rattling <input type="checkbox"/> Rocking<br><input type="checkbox"/> Rummaging <input type="checkbox"/> Other:                                                                                                                                                                          |
| Sexual Expressions of Risk   | <input type="checkbox"/> Explicit Sexual Comments <input type="checkbox"/> Public Masturbation<br><input type="checkbox"/> Touching Others – genitals <input type="checkbox"/> Touching Others – non-genitals<br><input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                 |
| Verbal Expressions of Risk   | <input type="checkbox"/> Insults <input type="checkbox"/> Screaming <input type="checkbox"/> Swearing <input type="checkbox"/> Threatening<br><input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Physical Expressions of Risk | <input type="checkbox"/> Biting <input type="checkbox"/> Choking Others <input type="checkbox"/> Grabbing <input type="checkbox"/> Hair Pulling <input type="checkbox"/> Hitting<br><input type="checkbox"/> Kicking <input type="checkbox"/> Physically Protective <input type="checkbox"/> Pinching <input type="checkbox"/> Punching <input type="checkbox"/> Pushing<br><input type="checkbox"/> Scratching <input type="checkbox"/> Self-Injurious <input type="checkbox"/> Slapping <input type="checkbox"/> Spitting <input type="checkbox"/> Throwing<br><input type="checkbox"/> Other: |
| Resists/Refuses Treatment    | <input type="checkbox"/> Medication <input type="checkbox"/> Assessments <input type="checkbox"/> Personal Care <input type="checkbox"/> Bathing<br><input type="checkbox"/> Dressing <input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                                            |
| Sleep Disturbances           | <input type="checkbox"/> Day/Night Reversal <input type="checkbox"/> Interrupted Sleep <input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Psychosis Symptoms           | <input type="checkbox"/> Hallucinations – Auditory <input type="checkbox"/> Hallucinations – Visual <input type="checkbox"/> Illusions<br><input type="checkbox"/> Delusions <input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                                                     |
| Ingestion of Foreign Objects | Comment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Elopement/ Exit Seeking      | Comment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Threat to Self               | <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Suicidal Attempt<br>Comment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Depression                   | Comment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Anxiousness                  | Comment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Other                        | Comment:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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**POA/SDM**

|                                                                                                                                                          |       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| Treatment decisions made by:                                                                                                                             |       |
| <input type="checkbox"/> Self,<br><input type="checkbox"/> POA/POA's<br><input type="checkbox"/> SDM<br><input type="checkbox"/> Public Guardian/Trustee |       |
| Name:                                                                                                                                                    |       |
| Relationship to patient:                                                                                                                                 | Phone |
|                                                                                                                                                          |       |
| Name:                                                                                                                                                    |       |
| Relationship to patient:                                                                                                                                 | Phone |
|                                                                                                                                                          |       |
| Name:                                                                                                                                                    |       |
| Relationship to patient:                                                                                                                                 | Phone |

**Please send completed referral to GABU via fax: 705-876-5837 or email: GABUfax@prhc.on.ca**  
**Please confirm referral has been received by contacting GABU Coordinator: 705-743-2121 x. 4303**

| To be completed by GABU staff only  |                                     |                                    |
|-------------------------------------|-------------------------------------|------------------------------------|
| Referral Receival Date (DD/MM/YYYY) | Referral Approval Date (DD/MM/YYYY) | Referral Decline Date (DD/MM/YYYY) |
|                                     |                                     |                                    |

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**PRHC**  
 Peterborough Regional  
 Health Centre

Peterborough Regional Health Centre

## Geriatric Assessment and Behavioural Unit Repatriation Agreement

Peterborough Regional Health Centre (PRHC) requests assurance and compliance from the referring institution that they will repatriate this patient/resident back to this sending institution once the Geriatric Assessment and Behavioural Unit (GABU) health team has determined a patient's treatment is completed or in accordance with Ministry of Long-Term Care (MOHLTC) guidelines as applicable.

The referring institution agrees to accept repatriation of this patient/resident, following notification from PRHC that the patient is ready for discharge. The exact length of stay is determined on an individual basis, however, will align with the maximum duration dictated by MOHLTC guidelines if applicable.

This referring institution understands and agrees to be involved in the program status conferences (post admission and pre-discharge meetings) to support the success of care plan interventions and treatment continuity upon discharge.

This referring institution agrees to collaborate with PRHC in discharge planning and to support implementation of the recommended care plan upon this patients/residents return. This referring institution agrees to resume care of this patient/resident in a manner consistent with their assessed care needs and the discharge plan provided by the GABU care team.

In the event that a medical presentation occurs (i.e. constipation, pain, UTI), where medical presentation impacts a 60-day LOA, a 30-day medical extension may be requested.

In the event that the referring institution is unable to accept repatriation within the agreed timeframe, the institution will promptly notify PRHC and work collaboratively with PRHC and system partners to identify a timely and appropriate transition plan.

The referring institution will designate a Role/Department responsible for coordinating repatriation and discharge planning:

Role/Department Name: \_\_\_\_\_

Email/Phone: \_\_\_\_\_

I acknowledge that my signature indicates I have read and understood the provisions outlined in this agreement and agree to the repatriation agreement.

Referring Institution: \_\_\_\_\_

Name of Manager/Director: \_\_\_\_\_

Signature of Manager/Director: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_\_

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### For GABU Staff Only

Patient Name: \_\_\_\_\_ Date of Birth (DD/MM/YYYY): \_\_\_\_\_ K#: \_\_\_\_\_

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**PRHC**  
Peterborough Regional  
Health Centre

## Geriatric Assessment and Behavioural Unit (GABU)

### Consent for Referral

The Geriatric Assessment and Behavioural Unit (GABU) is a specialized 12-bed inpatient unit at Peterborough Regional Health Centre (PRHC). The program provides specialized assessment and care for those 65 years or older living with dementia who exhibits responsive behaviours, including motor expressions, verbal expressions, verbal expressions of risk, physical expressions of risk and sexual expressions of risk. The purpose of this referral is to determine an individual's eligibility and appropriateness for a GABU admission. If accepted, a separate informed consent will be obtained prior to admission.

I, \_\_\_\_\_, (print name), am the

☐ Power of Attorney for Personal Care (POA)

☐ Substitute Decision Maker (SDM)

for: \_\_\_\_\_ (print patient/applicant name)

I confirm that I have the legal authority to provide consent on behalf of the individual named above.

#### I consent to:

1. A referral to the Geriatric Assessment and Behavioural Unit for consideration of admission;
2. The collection, use, and disclosure of relevant personal health information for the purpose of:
  - a. Assessing eligibility and appropriateness for the program
  - b. Care planning and coordination
3. The sharing of this information among healthcare professionals involved in the referral and assessment process, in accordance with the Personal Health Information Protection Act ON, 2004.

This consent is voluntary and I understand that I may refuse or withdraw consent at any time, subject to legal or contractual limitations. I understand that withdrawing consent may affect the ability to complete the referral or assessment. If you do wish to withdraw the application, please contact the GABU Coordinator at 705-743-2121 x. 4303.

I understand that only the information necessary for the purposes described above will be shared. I acknowledge that I have had the opportunity to ask questions and received satisfactory answers.

Name of POA/SDM: \_\_\_\_\_

Signature of POA/SDM: \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_\_

Witness name: \_\_\_\_\_

Witness signature: \_\_\_\_\_

Verbal consent provided by: \_\_\_\_\_

Verbal consent obtained by: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_\_

#### Interpreter Consent from a Non-English-Speaking SDM/POA

I acknowledge that I have interpreted the information given to me about GABU and the content of this consent form to the person giving consent and I believe to the best of my ability that the person understands the information.

Name of Interpreter: \_\_\_\_\_

Signature or "by telephone": \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_\_