

Geriatric Assessment and Behavioural Unit (GABU) Acute Care - PRHC Internal Application

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

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
- ☐ 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: ☐ Male	☐ Female	☐ Non-binary
OHIP #:		
Allergies:		
Address:		
Language:		Interpreter required: ☐ YES ☐ NO
Is the patient developmentally delayed: ☐ YES ☐ 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

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

Current Living Arrangement

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

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POA/SDM

Treatment decisions made by:	
☐ Self, ☐ POA/POA's ☐ SDM ☐ Public Guardian/Trustee	
Name:	
Relationship to patient:	Phone
Name:	
Relationship to patient:	Phone
Name:	
Relationship to patient:	Phone

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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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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): _____