The Residences of 1425 Bayview
Application to participate in the Day Program

Please note: The Residences of 1425 Bayview recognize and understand that your personal and health information is profoundly sensitive and confidential. In accordance with our Privacy Policy, once submitted to us, this form with be kept in a locked and secure place and will be reviewed only by personal health care workers employed by the Residences of 1425 Bayview solely for the purpose of determining whether the programs of the Residences can meet your needs or are suitable for you and to properly assist and support you if you choose to participate in any of the programs offered by the Residences.

Please fill out with parent and/or guardian for person care and/or healthcare professional, as fully as possible. Please feel free to provide answers on attachments if there is not sufficient room on this form. Please return completed form as indicated at the end of the form:

First Name: ______________________________

Initial: ______________________________

Last Name: ______________________________

Street Address: ______________________________

Apartment Number: ______________________________

City: ______________________________

Province: ______________________________

Postal Code: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

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Age: ____

Date of Birth: ____

Gender: ____

Are you considering applying for residence at 1425 Bayview? [ ] Yes [ ] No

Please describe your strengths, abilities and talents

____
____
____
____
____
____

What accomplishment are you most proud of?

____
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____
____

Please describe your challenges which have prompted you to apply to the Residences of 1425 Bayview

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What challenges do you experience when you are feeling well? How long have you been able to maintain a stretch of being well?)

When not feeling well?

Suggested steps, activities or approaches (when you are not feeling well):

Are you struggling with any other issues related to these challenges? Please describe.

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Are you struggling with intellectual or learning disability? Do you require assistance because of physical, cognitive, communication, behavioral, emotional challenges? If so, what kind of challenges? What kind of assistance?

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Please describe a problem you came across which you solved by yourself or with help. Please describe how you solved it.

____
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____
____

Do you have other physical health conditions or challenges (allergies, diabetes, hearing impairment)?

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____
____
____

Do you take medications? If so, please provide the name of the medication and the dosage and what the medication is intended to address.

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If you do not take your medication, what happens? How soon does this happen after you stop taking your medication?

____
____
____
____
____

Name of Your Psychiatrist

Agency: ____

Address: ____

____

____

Telephone Number: ____

Email Address: ____

Do you give consent for him/her to be contacted and (1) review your answers to this questionnaire; (2) to share your health history with us; and (3) to discuss with us whether your participation in the day program and (if applied for) the therapeutic assessment program and/or Enhanced Residence Program would be appropriate and beneficial for you and would not pose undue risk to yourself or others?

Yes ________ If yes, please sign here:____________________ and print your name and the capacity in which you are signing ie in person, or as attorney for personal care.

No _________

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Community Resources

Agency: ____

Address: ____

____

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Do you give consent for him/her to be contacted and (1) review your answer to this questionnaire with us; (2) to share your health history with us; and (3) discuss with us whether your participation in the day program and (if applied for) the therapeutic assessment program and/or Enhanced Residency Program would be appropriate and beneficial for you and would not pose undue risk to yourself or others?

Yes ________ If yes, please sign here:_________________ and print your name and the capacity in which you are signing i.e. in person, or as attorney for personal care.

No _________

Other services currently utilizing such as Speech and Language Pathologist; Occupational Therapist; Behavioral Therapist; DBT; CBT

Agency: ____

Address: ____

____

____

Telephone Number: ____

Email Address: ____

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Do you give consent for him/her to be contacted and (1) review your answer to this questionnaire with us; (2) to share your health history with us; and (3) discuss with us whether your participation in the day program and (if applied for) the therapeutic assessment program and/or Enhanced Residence Program would be appropriate and beneficial for you and would not pose undue risk to yourself or others?

Yes _______ If yes, please sign here____________________and print your name and the capacity in which you are signing ie in person or in the capacity as attorney for personal care.

No ________

Family and Emergency Contact Numbers:

First Name: ____

Last Name: ____

Street Address: ____

Apartment Number: ____

City: ____

Province: ____

Postal Code: ____

Telephone Number: ____

Email Address: ____

First Name: ____

Last Name: ____

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Street Address: ____

Apartment Number: ____

City: ____

Province: ____

Postal Code: ____

Telephone Number: ____

Email Address: ____

First Name: ____

Last Name: ____

Street Address: ____

Apt Number: ____

City: ____

Province: ____

Postal Code: ____

Telephone Number: ____

Email Address: ____

Are you employed?

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____

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Have you ever been employed?

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What education level have you achieved?

____
____
____

Risk/Behavior information:

Indicate beside each one if there have been any recent (within the last 12 months) or previous behavior of;

- Fire setting ____________________
- Suicide attempts ____________________
- Frequent thoughts about suicide ____________________
- Careless smoking ____________________
- Stealing; untrustworthiness ____________________
- Wanting to kill or maim people ____________________
- Threatening to kill or maim people ____________________
- Not taking your medication ____________________
- Substance abuse (alcohol and drugs; history; outcome) ____________________
- Verbal aggression ____________________
- Physical assault ____________________
- Sexually inappropriate behavior ____________________
- Destruction of property ____________________
- Problems with anger control and management ____________________
- Self-harm ____________________
- Running away - traveling in response to symptoms ____________________
- Making unfounded allegations ____________________
- Expressing high levels of distress ____________________

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- Major physical illness/disability/chronic pain ____________________
- Feelings of helplessness and/or hopelessness or that you have no control over your life
  ____
- Feeling unsafe while in the community or in open spaces or in enclosed spaces
  ____
- Feelings of intense fear caused by certain situations or creatures e.g. darkness, people in masks, dogs, spiders etc. Please provide particulars:
  ____
  ____
  ____
- Conflict with the law (please provide full history including any charges, convictions or pending charges)
  ____
  ____
  ____
  ____

Are you on probation and/or parole? (If yes please provide contact information for probation office)

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____
____

Do you enjoy social relationships? Do you make and keep friends easily or with difficulty?

____
____
____
____
____

How do you normally spend your free time i.e. watching television; sports; computers; by yourself; involved in clubs; hobbies; interests; friends?

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What recreational or social activities are you involved in and/or like to do at home or in the community?

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Are you OK with some of your time being taken up with structured activities?

____
____
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____

How are you with activities of daily living?
Please rate between 0 and 10

(0 meaning total support and 10 meaning no support)

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Personal hygiene	1-2-3-4-5-6-7-8-9-10
Care of personal living space	1-2-3-4-5-6-7-8-9-10
Cooking	1-2-3-4-5-6-7-8-9-10
Shopping	1-2-3-4-5-6-7-8-9-10
Finances	1-2-3-4-5-6-7-8-9-10
Transportation - can you use public transit independently?	1-2-3-4-5-6-7-8-9-10
Enjoying leisure time independently?	1-2-3-4-5-6-7-8-9-10
Taking medication with reminders and support?	1-2-3-4-5-6-7-8-9-10
Taking medication without reminders and support?	1-2-3-4-5-6-7-8-9-10
Attending appointments independently?	1-2-3-4-5-6-7-8-9-10

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Cognitive skills judgment/attention/planning/setting priorities)	1-2-3-4-5-6-7-8-9-10
Sleeping properly at night/staying awake during the day	1-2-3-4-5-6-7-8-9-10
Appetite – eating habits; not skipping meals	1-2-3-4-5-6-7-8-9-10
Doing Laundry independently	1-2-3-4-5-6-7-8-9-10

SAFETY PLAN: has there been one developed and if so what is it or please attach copy.

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CRISIS PLAN:

1. If you go into crisis, what should be done? What is needed?

2. When does your family know you are in crisis i.e. do you repeatedly say the same thing? Are there certain 'buzz' words or phrases which you say repeatedly when you are having an episode or displaying psychosis, anxiety, or some other state?

3. What does your family do when you are in crisis?

4. What are your triggers? What proactive steps can be taken to sooth and/or ground you?

5. How long is your escalation period i.e. is there a slow build up before it escalates or is it immediate?

6. How long before we call 911?

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7. Do you display any signs of aggression?

___

___

___

8. What self-soothing techniques do you use? Are these helpful?

___

___

___

Please tell us <u>anything else</u> you think we should know in order to support you and keep you and those around you safe and well.

___

___

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___

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___

___

Signed________________________ (Candidate applying) Dated: ___________

PRINT NAME in full______________________

Signed_________________________ (Parent/Family Member) Dated: __________

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PRINT NAME in full________________________

Signed__________________________ (if applicable, Attorney for Personal Care)

PRINT NAME in full________________________ Dated:___________________

Please return to: Sue Rosborough, Program Manager

The Residences of 1425 Bayview Inc.

1425 Bayview Avenue

Toronto, ON

M4G 3A9

Phone No.: 416-487-7982

Fax: 416-487-1310

E-mail: sue@residencesofbayview.com

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CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

____
Print Full Name

I hereby authorize the ____ to disclose personal health information

Name of Person/Agency Disclosing Information

to ____

Name of Person/Agency Requesting Information

of ____

Street Address　　City　　Province　　Postal Code

From the records of:

____

Print Client/Patient Name　　Date of Birth (dd/mm/yyyy)　　Health Record #

____

Street Address　　City　　Province　　Postal Code

____

Print Name of Witness　　Signature of Witness　　(If other than client/patient, print name and state relationship.)

Date: ______________________________

(dd/mm/yyyy)

This authorization may be withdrawn in writing at any time.

All Consent for Disclosure of Personal Health information forms must be delivered to the Health Records department [of what or where ????] to be processed. An administrative fee may be applied to cover photocopying and related costs.

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