THE RESIDENCES OF
1425 Bayview

Pre-residential Screening Form

****Please fill out each section as detailed as possible****

First Name: ______________________________
Initial: ______________________________
Last Name: ______________________________
Street Address: ______________________________
Apartment Number: ______________________________
City: ______________________________
Province: ______________________________
Postal Code: ______________________________
Phone Number: ______________________________
Email Address: ______________________________
Date of Birth: ______________________________
Gender: ______________________________

Housing History: (within the last five years and the reason for leaving):
Address: ______________________________
____
____
____

Type of Housing: ______________________________
Landlord/Agency Name: ______________________________
Phone Number: ______________________________
Email Address: ______________________________
Date moved in: ______________________________
Date moved out: ______________________________
Reason for leaving: ______________________________
Other comments related to housing history:
____
____
____
____
____

Psychiatric History:
How old were you when first diagnosed?

(a) **Primary Diagnosis:**

(b) **Secondary Diagnosis:**

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

What challenges do you experience when you are feeling well? Please describe i.e. energy level; appetite; concentration; memory/recall; sleep patterns etc.

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What challenges do you face when not feeling well?

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What coping skills do you find useful or interventions to assist you in maintaining your mental health?

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Have you been hospitalized in the past 2 years for mental health reasons? (Number of times and number of days)

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Are you struggling with intellectual disability? Do you require assistance because of cognitive; communication; behavioural; emotional challenges? If so, what kind of challenges? What kind of assistance?

____
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____

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

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____
____
____
____

Please include a copy of your most recent Psychological Assessment

Name of 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 Unit 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 i.e. in person, or as attorney for personal care.
No _________

Community Resources
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 Unit 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 i.e. in person, or as attorney for personal care.
No _________

Other services currently utilizing such as Speech and Language Pathologist; Occupational Therapist; Behavioural Therapist; DBT; CBT
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 Unit 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 i.e. in person, or as attorney for personal care.
No _________

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 Unit 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 i.e. in person, or as attorney for personal care.
No _________

Family Contact Numbers:
First Name: ____
Last Name: ____
Street Address: ____
Apartment Number: ____
City: ____
Province: ____
Postal Code: ____
Telephone Number: ____
Email Address: ____

First Name: ____
Last Name: ____
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: ____

Family History:
Briefly describe your family dynamics i.e. where you raised by both parents; do you have siblings; did any significant events occur in your childhood etc.

Education History:
What education level have you achieved?

Employment History:
Are you currently employed?

Have you ever been employed?

Risk/Behaviour information:
Indicate beside each one if there have been any recent behaviour (within the last 12 months) or previous behaviour of if it does not apply. Please provide details:

- Self-abuse ____
- Fire setting ____
- Suicide attempts ____
- Frequent thoughts about suicide____
- Careless smoker ____
- 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 behaviour ____
- Destruction of property ____
- Problems with anger control and management ______________________________
- Self-harm ____
- Running away ____
- Making unfounded allegations ____
- Expressing high levels of distress ____
- Major physical illness/disability/chronic pain _______________________________
- Feelings of intense fear caused by certain situations or creatures i.e. darkness, people in masks, dogs, spiders ____
- 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 ___________________________ ____
- Stealing; untrustworthiness ____

Have you ever been or are you currently on probation and/or parole? (If yes please provide contact information for probation office as well as reasons why)

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Social Interests:
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; isolates self; involved in clubs; hobbies; interests; friends?

What recreational or social activities are you currently involved in within the community?

Please describe your strengths, abilities, and talents:

What accomplishments are you most proud of?

What is presently expected of you in terms of functioning as a contributing member of your present living environment?

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Are they agreeable with some of your time being taken up with structured activities?

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What are your goals for the future? (include both short and long-term goals)

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Activities of Daily living:

Please rate between 0 and 10
(0 meaning total support and 10 meaning no support)

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
Enjoy 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
Attending appointments independently	1-2-3-4-5-6-7-8-9-10
Cognitive skills (judgment; attention; planning)	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 of.

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CRISIS PLAN:

1. **When do you or your family know when you are in crisis** i.e. do you repeatedly say or do things? Is there a 'buzz' word when you are having an episode or displaying psychosis; anxiety; or other state.

   ____
   ____
   ____
   ____
   ____

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

3. **What are your triggers** – what proactive steps can be taken to sooth and/or ground you.

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

5. **How long before we call 911**?

6. Do you have a prescription for a PRN?

7. Do you display any signs of aggression?

8. **What self-soothing techniques do they use**?

Please tell us anything else you think we should know to support you and keep you and those around you safe and well.

Please return to:

Sue Rosborough, Program Director
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

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 to be processed. An administrative fee may be applied to cover photocopying and related costs.

T H E R E S I D E N C E S O F

1425 Bayview

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I ____
Print Full Name

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

____________________ Signature of Witness ____________________

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

Date: ____________________
(dd/mm/yyyy)