Supporting the journey to independence

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: ______________________

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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: ______________________

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PSYCHIATRIC HISTORY:
How old were you when first diagnosed?

(a) Primary Diagnosis:

(b) Secondary Diagnosis:

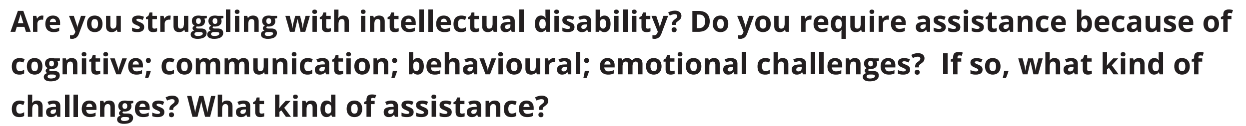
Do you take medication? If so, please provide the name of the medication and the dosage and what the medication is intended to address.

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

What challenges do you face when not feeling well?

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

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



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?

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

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: ______________________________

____

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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

- ☐ **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 [CONT'D]

Agency: ______________________________
Address: ______________________________

____

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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: ______________
Phone Number: ______________________
Email Address: ______________________

First Name: ______________________
Last Name: ______________________
Street Address: ______________________
Apartment Number: ______________ City: ______________
Province: ______________ Postal Code: ______________
Phone Number: ______________________
Email Address: ______________________

First Name: ______________________
Last Name: ______________________
Street Address: ______________________
Apartment Number: ______________ City: ______________
Province: ______________ Postal Code: ______________
Phone Number: ______________________
Email Address: ______________________

First Name: ______________________
Last Name: ______________________
Street Address: ______________________
Apartment Number: ______________ City: ______________
Province: ______________ Postal Code: ______________
Phone 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)

______

______

______

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?

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

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

ACTIVITIES OF DAILY LIVING

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

Activity										
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.

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?

How long before we call 911?

Do you have a prescription for a PRN?

Do you display any signs of aggression?

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.

THE RESIDENCES OF
1425
BAYVIEW
Supporting the journey
to independence

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I ____

Print Full Name

hereby authorize the ____

Name of person/Agency Disclosing Information

to disclose personal health information

to ____

Name of person/Agency Disclosing Information

of ____

Street Address *City* *Province* *Postal Code*

From the records of:

____

Street Address *City* *Province* *Postal Code*

______________________ ______________________

Signature of Witness *Date (DD/MM/YYYY)*

______________________ ______________________

Print name of witness *If other than client/patient, print name and state relationship*