THE RESIDENCES OF 1425 BAYVIEW

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: _____

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.

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: _____

_____

_____

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: _____

_____

_____

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)

_____

_____

_____

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?

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)

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

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