Early Intervention Screening Tool for Individuals 75+

Ask: “Do you need any supervision or help to:
- Take a bath or shower? (includes transferring in and out of tub/shower)
- Make decisions about daily tasks? (when to get up, have meals, clothing, etc.)
- Dress or undress below the waist?
- Move between locations on the same floor level?

Note: Yes to any of the above questions would prompt a “YES” and movement to the next question

Ask: “Do you have any conditions that make your health unstable?
Examples: Any disease or condition that causes fluctuating, precarious, or unstable functioning, mood, or behaviour. Unstable Congestive Heart Failure, Unstable Chronic Obstructive Lung Disease.

Ask: “Do you sometimes feel short of breath when performing daily tasks?
Includes: Dyspnea at rest or during normal daily tasks and movement.

Stop - Refer to CCAC

Ask: “Does your family or friends feel overwhelmed by your illness or condition?
Includes: Using your best clinical judgment to make the determination.

Ask: “In the past three days, have you felt sad, depressed or hopeless?

Stop - No CCAC Referral Required

Completed By: ___________________________ Date: ___________________________

Referral to CCAC Completed and Sent: Yes □ No □
Primary Care

Early Intervention Screening Tool for Individuals 75+

*interRAI Preliminary Screener® Assessment Urgency Decision Tree*

**Information:**
The Early Intervention Screening Tool: This Tool is derived from the Assessment Urgency Preliminary Screener embedded in the InterRAI ED Assessment (a focused geriatric assessment) and is predictive of the need for follow-up assessment and risk of poor patient outcomes.

**Purpose:** To help prioritize referrals to CCAC from primary care physicians for further assessment.

**Target Population:** Adults age 75 or older.

**Instructions:** Please complete both sides of this tool. The question prompts will guide the decision of whether or not to refer to CCAC.

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**Screening Tool to Identify High Risk Seniors

**PHYSICIAN TO COMPLETE - REQUIRED INFORMATION**

Patient Name: __________________________ Phone #: ______________________

Address: _________________________________________________________________

Health Card #: __________________________

☐ New Cognitive Impairment diagnosis

☐ Indication that cognitive impairment was deteriorating

☐ The client was informed that they are being referred to the HNHB CCAC and they have given verbal Consent for services.

Fax referrals to: 1-866-655-6402 HNHB CCAC Main Office

Additional Health Professional Notes:

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Referring Physician Name: __________________ Date Referral Faxed: _____________

Referring Physician Fax#: __________________

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CCAC Report Back to Physician (CCAC TO COMPLETE):

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Date Referral Returned: __________________