

North Saskatchewan Dementia Assessment Team and Unit

The Dementia Assessment Outreach Team provides support to individuals with a primary diagnosis of dementia who are experiencing responsive behaviours that are not being managed in their current home. The Team provides an interdisciplinary assessment and recommendations, with the goal of stabilizing responsive behaviours in the client's current environment. We provide access to social work, psychology, occupational therapy, geriatric psychiatry and pharmacy.

Typically, referrals come through the Dementia Assessment Outreach Team and the process will begin with an assessment and recommendations for behaviour management through outreach services. If behaviours cannot be resolved through outreach services, the team may consider the client for admission to the Dementia Assessment Unit. The Dementia Assessment Unit is a 5-bed secure unit housed within Parkridge Centre.

To make a referral

- Referrals may be generated from the community, acute care, or long-term care
- Any healthcare provider may complete the referral form
- Physician or Nurse Practitioner involvement is essential to facilitate recommendations from the team
- Community resources must first be accessed and exhausted
- Referral forms can be found at our website:

[North Saskatchewan Dementia Assessment Outreach Team | SaskHealthAuthority](#)

Accompanying Documentation

*****Important: Include ALL Referral Criteria when submitting the referral form*****

1. Completed behaviour tracking form. This tool is used to assess a person's behaviour over a 24-hour cycle for up to 7 days to determine the occurrence, frequency, and duration of behaviours of concern. Please use the attached Dementia Observation System (DOS) form.
2. Medication Administration Record (MAR), including PRN medications (or list of medications if residing in the community)
3. Blood Work (< 3 months) including CBC, Renal and Liver panel, TSH, B12 and folates, HgA1c, Blood glucose, Calcium, Vitamin D, Urinalysis, and Urine C&S (if UTI guideline criteria has been met)
4. Most recent MDS (long-term care form), including Outcome Scales and CAP reports (if client is a resident of a long-term care home)

Sincerely,

Dementia Assessment Team and Unit

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