**\*\*For each referral, please print a copy of the Standardized RCM Referral Form from the website** [**http://bellwoodscentres.org**](http://bellwoodscentres.org) **under Centralized Referral Management, as it may be revised. Thank you.**

Client First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The **Reintegration Care Models (RCM)** being piloted in Toronto Central Local Health Integration Network (LHIN) are designed to support the transition of patients from hospital to the community who are ALC or who are at high risk of

becoming ALC without additional resources and supports. These initiatives are needs based, time limited, and with no additional fee for the program (cost for incidentals will be reviewed per site/per program as appropriate).

**Referral Process:**

1. **Complete** all 4 sections of this form.
2. **E-mail** [crm.team@one-mail.on.ca](mailto:crm.team@one-mail.on.ca) or Fax **647-345-8999** referral to Centralized Referral Management (CRM) for the RCM.
3. CRM to determine **eligibility** and referral will be assigned to the best **matched** Health Service Provider (HSP) based on clients’ unique needs.
4. The HSP will follow-up with referral source and/or patient/caregivers to gather further information, and determine **fit**. If it is a fit, the formal intake assessment process will start.
5. If it is not a fit, HSP will alert CRM Team and matching efforts will resume.

Please contact CRM at **416-859-4376** for further information from 8:30 am to 4:30 pm Monday to Friday.

**Section A: Referral Source/Patient/Caregiver Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Source Information** | | | | | | | | |
| Referrer’s First Name: | |  | Last Name: | |  | | | |
| Organization and site: | |  | Title: | |  | | | |
| Phone Number: | |  | E-mail Address: | |  | | | |
| Date of Referral:  *(dd/mm/yyyy)* | |  | Preferred communication  Method: | | Phone  Email | | | |
| **Patient Information** | | | | | | | | |
| Date of Birth:  (*dd/mm/yyyy)* |  | | Gender Identity: | | | 🞎 He/Him 🞎 She/Her  🞎 They/Them | | |
| Ontario health card  Number & version code: |  | | Discharge Date: | | |  | | |
| Phone Number: |  | | E-mail Address: | | |  | | |
| Discharge Destination: | Is this a pre-admit home address? 🞎 Yes 🞎 No    Street and Unit:  City: Prov.:  Postal Code: | | | | | | | |
| Is translation required? | 🞎 Yes 🞎 No | | If yes, which language? | | |  | | | Is Client capable of making personal care decisions? | 🞎 Yes 🞎 No. If no, please complete:  Name of Substitute Decision Maker (SDM) providing consent for referral: Relationship/Agency: Phone:  E-mail: |
| If patient is ALC please insert start date of  designation: |  | | If at risk for ALC, insert  potential ALC date if  different from planned d/c: | | |  | | |  |  |
| **RAI Assessment (if available)** | | | | | | | | |
| Is a recent RAI Assessment available? | 🞎 Yes 🞎 No | | Date of most recent RAI  assessment: *(dd/mm/yy)* | | | |  | |
| Consent given to share RAI: | 🞎 Yes 🞎 No | | Assessment attached? | | | | 🞎 Yes 🞎 No | |
| Assessment on IAR? | | | | 🞎 Yes 🞎 No | |
| Type of RAI Assessment | 🞎 inter-RAI CHA 🞎 RAI-HC 🞎 RAI-PC | | | | | | | |
| RAI Assessment Outcomes  Scores: | MAPLe: CHESS: ADL: IADL: | | | | | | CPS : | DRS: |
| **Primary Caregiver Information** | | | | | | | | |
| First Name: |  | | | Last Name: | | |  | |
| Phone Number: |  | | | E-mail Address: | | |  | |
| Home Address if not the  same as patient: | Address:  Unit:  City: Prov.:  Postal Code: | | | Relationship: | | |  | |
| Does the caregiver live with the care recipient? | 🞎 Yes 🞎 No | | | Is the primary caregiver the emergency contact? | | | 🞎 Yes 🞎 No | |
| Has the patient been formally deemed incapable of making personal care decisions? | 🞎 No 🞎 Yes - If yes, please complete:  Name of Substitute Decision Maker (SDM) providing consent for referral if different then the above noted caregiver:  Relationship/Agency: Phone:  E-mail: | | | | | | | |

**Section B: Requested Services –** Check one or more services requested

🞎 **Reintegration Care Units (RCU)**

These are short-term transitional units in the community that allow patients a safe and supportive place to go post-hospital discharge from hospital, to prepare/plan/await their next community transition (home, new community housing, more supportive housing etc). These sites are all time-limited (varies per program) thus a plan for a discharge destination post-RCU **is required** and discharge plan will commence upon admit. Your patient will be matched to the HSP by their unique needs (see below) and unit availability, with consideration given to geography if possible.

**General inclusion criteria**:

* Require 24-hour access to personal support workers (PSW) for assistance with ADL/IADL tasks
* Designated ALC or at risk of ALC with complex care needs (i.e. mental health; chronic medical conditions) or complex social needs
* HSP discharge plan confirmed by referral source, client, and family/support network

**General exclusion criteria**:

* Requires frequent/24 hour nursing supports that cannot be provided by LHIN Home and Community Care or on-site RPNs (varies per providers)
* Has behaviours that cannot be adequately supported in the community (will vary per site)
* Some of the facilities do have age specific criteria, the CRM Team will consider those in matching

**Personal Care Reintegration Units (PCRU)**: Bellwoods, ESS Support Services, LOFT at White Squirrel Way, Reconnect Community Health Services, The Neighbourhood Group and Woodgreen Community Services.

**Clinical Care Reintegration Units (CCRU):** Hillcrest Reactivation Centre, Pine Villa, St. Hilda’s and The Rekai Centres Transitional Care Unit

🞎 **Caregiver ReCharge**

The focus for these programs is on caregiver relief to improve their capacity to transition their loved one home and continue to provide care for the client in the community while promoting their own wellbeing. These specialized respite services include in- home respite (day/night), away from home overnight respite, and/or supervised programming in a group setting during the day (i.e. Adult Day Programs).The duration of these free services will be time limited (varies per program). Please select requested program(s) below and patients will be matched to the HSP by their unique needs, vacancies and with the In-home services, geography.

**Inclusion criteria**:

* Patient has a caregiver providing support to them in the client’s home
* Designated ALC or at risk of ALC with complex care needs (i.e. mental health; chronic medical conditions) and/or noted caregiver distress/risk of burnout.
* Family must agree to short-duration of service (depending on the program)

**Exclusion criteria**:

* Patient has behaviours and they are not easily re-directed

🞎 **In-Home Respite –** West Toronto Support Services for Seniors, West Neighbourhood House, Storefront Humber

Inc., The Neighbourhood Group and Bellwoods

🞎 **Adult Day Program** – Reconnect Community Health Services and Providence Healthcare

🞎 **Overnight Respite Stays Out of the Home** – Bellwoods, ESS Support Services, Reconnect Community Health Services and Providence Healthcare

**Section C: Requested Services –** Check all that apply so that client’s needs can be matched to the appropriate provider

|  |  |  |  |
| --- | --- | --- | --- |
| 🞎 Requires mechanical lift | 🞎 Needs IV | 🞎 Suctioning | 🞎 Bariatric |
| 🞎 Requires 1 person transfer | 🞎 Not able to be in an independent apartment setting with only staff present for pre-planned support and if called for emergency. | 🞎 Will be attending ongoing treatment (ie. Chemo, rehab OP, dialysis) | 🞎 Client has dietary restrictions that would require meals be fully prepared |
| 🞎 Dependent for mobility | 🞎 Unmanaged behaviours | 🞎 Ostomy support required | 🞎 Support with medication |
| 🞎 Requires supervision and/or cueing only for ADLs | 🞎 Behaviours but easily re-directed | 🞎 Unable, due to behaviours, share a room (would need to be able to be alone for hours) | 🞎 Administration of medication |
| 🞎 Intermittent Catheterization support needed | 🞎 Requires wander guard | 🞎 Cognitive impairment impacting judgement | 🞎 Unwilling or unable to participate in daily activation programming |
| 🞎 Requires support with a bowel/bladder routine | 🞎 Requires a locked unit | 🞎 Smoker who requires escort/assistance | 🞎 Preferred discharge destination is LTC |
| 🞎 Hands on assistance required with ADLs | 🞎 Has mental health challenges impacting transition home | 🞎 Client or family unable to participate in even simple meal prep/planning | 🞎 Other: ……………………………….. |
| 🞎 Assistance with feeding | 🞎 Non-weight-bearing | 🞎 Requires wound care | 🞎 Other: ………………………………... |
| 🞎 G-feeding support required | 🞎 Oxygen needs | 🞎 Unable to direct their own care |  |

**Comments:**

**\_**

**Section D: Consent –** Please review with the patient and obtain verbal consent

* Patient information will be shared with the Health Service Providers (HSP) for the Reintegration Care Model (RCM) Program for the purpose of arranging and providing services only. Patient and caregiver privacy will be respected and be maintained within the legislation guiding the sharing of personal health information (PHI).
* The **Reintegration Care Models (RCM)** Program is for patients who are in hospital who would benefit from some additional support to return to the community. Patient /caregivers/supporters understand the program is time limited with a discharge date set on admit.
* There are no fees for the programs but patient will be responsible for personal items (i.e. medications, incontinence supplies, therapeutic equipment and in some facilities, meals) and travel to and from the sites, as needed.
* Patient will be matched to the provider that best meets their unique needs and though geographical preference is considered, it may not be possible to accommodate.

Reviewed with: \_\_\_ Relationship to patient, if not patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (dd/mm/yyyy): \_\_\_\_\_\_\_\_

|  |
| --- |
| For Use by Centralized Referral Management Staff Only. Thank you. |

If you have any questions or concerns about this form, we welcome your feedback – please contact:

Anne Dumais, Manager of Centralized Referral Management at [anne.dumais@one-mail.on.ca](mailto:anne.dumais@one-mail.on.ca)