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

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| Client Name: | Click or tap here to enter text. |  |

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 sections of this form. Please note, if the form is not complete/missing information, there may be a delay in matching to a Health Service Provider partner.
2. **E-mail** [crm.team@one-mail.on.ca](mailto:crm.team@one-mail.on.ca) (preferred) or Fax 365-300-5758 or 647-345-8999 the 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. For the RIU/RCU the HSP will review the detailed documentation, confirm the fit and then reach out to the Referral Source to plan for the transition.  The Referrer may still be asked to submit further documentation such as copies of notes, repatriation letters, signed orders (for wound care, IV, Meds etc.) and consent forms as per each individual RCUs requirements (but no further detailed application with this new form!).  For ReCharge, the HSP will reach out directly to the family post-discharge unless you indicate otherwise.
5. If your patient it is not a fit, the HSP will alert CRM Team, you will be alerted of any challenges or delays in matching and matching efforts will resume.  With one form used by all our HSP partners, the information can easily be redirected with no additional applications or work on the part of the Referral Source.

Please contact CRM at **416-859-4376** or **416-696-9663 ext. 221** for further information from 8:30 am to 4:30 pm Monday to Friday.

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| **SECTION 1: TORONTO CENTRAL LHIN HOSPITAL REFERRAL SOURCE INFORMATION** | | | | |
| Referrer’s Name: | Click or tap here to enter text. | Referrer’s Title: | | Click or tap here to enter text. |
| Organization: | Click or tap here to enter text. | Unit Client is on: | | Click or tap here to enter text. |
| Phone Number of Referring Contact: | Click or tap here to enter text. | E-mail Address of Referring Contact: | | Click or tap here to enter text. |
| Date of Referral:  (dd/mm/yyyy) | Click or tap here to enter text. | Preferred communication method: | | Telephone  Email |
| **SECTION 2: GENERAL PATIENT INFORMATION** | | | | |
| First Name and Middle Initial: | Click or tap here to enter text. | Last Name: | | Click or tap here to enter text. |
| Date of Birth:  (dd/mm/yyyy) | Click or tap here to enter text. | Gender Identity: | | He/Him  She/Her  They/Them |
| Gender | | Male  Female  Other |
| Ontario Health Card number & Version Code | Click or tap here to enter text. | Planned Discharge Date:  (dd/mm/yyyy) | | Click or tap here to enter text. |
| Telephone number: | Click or tap here to enter text. | E-mail Address: | | Click or tap here to enter text. |
| Pre-admit Address: | Click or tap here to enter text. | | | |
| Did/does this client live alone at this address:  Yes  No | | | |
| Does this person speak English? | Yes  No | Is interpreter required? | Yes  No  Language: Click or tap here to enter text. | |
| Has this patient been deemed incapable of making personal care decisions? | Yes, formally assessed  Yes, hospital team opinion  No | If yes, name of person providing consent for referral? | Name: Click or tap here to enter text.  Relationship: Click or tap here to enter text.  Phone: Click or tap here to enter text.  POA  SDM  PGT | |

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| **SECTION 3A: PRIMARY SUPPORT(S) – FAMILY/FRIENDS/OTHER** | | | | | | | |
| First Name: | Click or tap here to enter text. | | | Last Name: | | Click or tap here to enter text. | |
| Telephone Number: | Click or tap here to enter text. | | | E-mail Address: | | Click or tap here to enter text. | |
| Does this supporter live with the patient: | Click or tap here to enter text. | | | Relationship: | | Click or tap here to enter text. | |
| Emergency contacts other than primary support:  Yes  No | Name #1:  Address:  Phone:  Relationship:  Name #2:  Address:  Phone:  Relationship: | | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | | | | |
|  | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | | | | |
| **SECTION 3B: PATIENT’S PROFESSIONAL CIRCLE OF CARE** | | | | | | | |
| Primary care doctor (GP): | | Click or tap here to enter text. | | | Telephone #: | | Click or tap here to enter text. |
| Psychiatrist: Click or tap here to enter text. | | Telephone #: Click or tap here to enter text. | | | | | |
| Other supports  BSS/BSTR  Case Management  Home & Community Care  Housing Worker  Other  Specialists Following: Click or tap here to enter text. | | Contact information and any Follow-up Appointments scheduled: Click or tap here to enter text. | | | | | |

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| **SECTION 4: REQUESTED SERVICES** | | | | | |
| **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. Every effort will be made to match your patient to the HSP based on their unique needs (see below) and unit availability, with consideration given to geography and personal preference, if possible. | | | | | |
| **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. | | | | | |
| **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 5: ALC DESIGNATION & DISCHARGE DESTINATION** | | | | | |
| Has the patient been designated ALC | Yes  No  Date:Click or tap here to enter text. | Has the patient been designated at high risk for ALC: | | Yes  No | |
| Why does the caregiver/patient need ReCharge services at this time: | Click or tap here to enter text. | | | | |
| Why does the patient need a Reintegration Care Unit (RCU) at this time/ what are the goals for the RCU stay: | Click or tap here to enter text. | | | | |
| What is the post-RCU discharge destination and what steps are being taken for that destination to be ready for the client (including need for cleaning, equipment etc.) - must be achievable within the duration of the RCU max admit or shorter: | Click or tap here to enter text. | | | | |
| Confirmed with supports:  Yes  No |
| Are there any potential environmental barriers that may impact transition to this location:  Yes  No | If Yes, please explain (i.e. stairs, lip to doorway, bathroom on another floor) and provide any info. on plan to address these. Click or tap here to enter text. | | | | |
| If this is not the client’s pre-admit home, please provide some info. on where they were living and why they cannot return: | Click or tap here to enter text. | | | | |
| Has the patient applied to Long-Term Care and been accepted | Yes  No | | Date of LTC application:  \*Please provide a summary of choices and length of waiting for each – this is required for any client waiting at RCU for LTC | | Click or tap here to enter text. |

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| **SECTION 6: RAI ASSESSMENT (THIS IS REQUIRED IF CLIENT WAITING AT RCU FOR LTC)** | | | | | | | | |
| Is a recent RAI assessment available? | | Yes  No | | | Date of most recent RAI assessment: (dd/mm/yyyy) | | Click or tap here to enter text. | |
| Consent given to share RAI: | | Yes  No | | | Assessment Attached? | | Yes  No | |
| Assessment on IAR? | | Yes  No | |
| RAI Assessment Outcomes Scores: | | MAPLe: Click or tap here to enter text. | CHESS: Click or tap here to enter text. | | ADL: Click or tap here to enter text. | IADL: Click or tap here to enter text. | CPS: Click or tap here to enter text. | DRS: Click or tap here to enter text. |
| **SECTION 7: HEALTH STATUS (PHYSICAL HEALTH, MENTAL HEALTH AND/OR SUBSTANCE ABUSE)** | | | | | | | | |
| Height:  Weight: | Click or tap here to enter text.  Click or tap here to enter text. | | | Allergies: Click or tap here to enter text.  None | | | | |
| Infectious Risks | | Lice/Scabies  MRSA  VRE  TB  C. Diff  Recent Respiratory Infection  Click or tap here to enter text.  Isolation Required:  Yes  No  None | | | | | | |
| Falls Risk | | Yes  No  # of falls in last 2 weeks: Click or tap here to enter text.  Last Fall: Click or tap here to enter text.  STRATIFY or Hendrich Score if available: Click or tap here to enter text. | | | Vision  Functional  Impaired  Aids Used: Click or tap here to enter text. | | | |
| Hearing  Functional  Impaired  Aids Used: Click or tap here to enter text. | | | |
| Diagnosis - please include Physical AND/OR Mental Health: | | Click or tap here to enter text. | | | | | | |
| Brief Past Medical, Cognitive and/or Mental History. Please include consult notes if available. | | Click or tap here to enter text. | | | | | | |
| Any Active Addictions:  Yes  No | | Please explain including substance and any current treatment:  \*Please note on-site use of alcohol and non-prescribed drugs are prohibited  Click or tap here to enter text. | | | | | | |
| Smoker: | | Yes  No | | | Escort to Smoke outside needed: | | Yes  No | |
| Wounds:  Yes  No | | Describe wound. Include list of supplies, dressing orders and drainage type if applicable (may be separate attachment): Click or tap here to enter text. | | | | | | |
| \*\*Please note for RCU’s client must have 1 or more weeks of supplies at the time of transition a signed dressing orders will be required prior to transition to a CCRU with Nursing in house | | | | | | |
| Planned follow-up post hospital discharge:  Yes  No | | Chemotherapy – Details: Click or tap here to enter text.  Hemodyalisis – Details: Click or tap here to enter text.  Rehab – PT, OT etc.- Details: Click or tap here to enter text.  Other.:Click or tap here to enter text. | | | | | | |
| Palliative Care | | Does the client have a palliative diagnosis:  Yes  No  If yes,  Estimated prognosis: Click or tap here to enter text.  Advanced Directives (please attach a copy of DNRs): Click or tap here to enter text.  EMS Provincial Sheet done (please attach a copy):  Resources and Supports who will follow: Click or tap here to enter text. | | | | | | |
| Other Special Needs that may impact transitions: | | Oxygen specify: Click or tap here to enter text.\*Funding and delivery to be arranged before transition  Bipap/cpap –client managed and t hey have their own equipment  Tracheostomy –client managed  Suctioning – long standing trach/suction – client managed  Hemodialysis  Peritoneal Dialysis – client managed  Blood sugar testing  Methadone | | | | | | |
| Restorative Potential if acute changes to status: | | Yes  No  Details/Plan:Click or tap here to enter text. | | | | | | |
| Medications: | | Please include a detailed current medication list/Medication Administration Record. Mark any recent medication changes (mark and date). A signed medication list just prior to discharge will be required  Click or tap here to enter text. | | | | | | |
| \*St. Hilda’s and Rekai do have pharmacies however client must have at least 24 hours of meds and the final med list but be submitted by 3PM the day before admit. All other RCUs require the client come with their own medication with a plan on how they will get more for the duration of the stay. | | | | | | |

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| **Cognitive Status** | **Please check one** |  |
| Able to direct their own care | Yes  No | Click or tap here to enter text. |
| Able to express their needs (i.e. hot, cold, tired) | Yes  No | Click or tap here to enter text. |
| Able to follow instructions | Yes  No | Click or tap here to enter text. |
| Memory challenges – short term | Yes  No | Click or tap here to enter text. |
| Memory challenges – long term | Yes  No | Click or tap here to enter text. |
| Carry-Over/New Learning | Yes  No | Click or tap here to enter text. |
| Impaired Judgment impacting safety | Yes  No | Click or tap here to enter text. |
| Poor Insight into personal care needs | Yes  No | Click or tap here to enter text. |
| Managing medication | Yes  No | Click or tap here to enter text. |
| Able to participate in group settings | Yes  No | Click or tap here to enter text. |
| Other cognitive issues that may impact transition | Yes  No | Click or tap here to enter text. |
| If cognitively impaired, please include any formal assessment scores such as MOCA/MMSE/RUDAS | Click or tap here to enter text. | |
| **Behavioural Status (client safety & risk)**  **\*Note: Please include current and behaviours noted in the last 2 months** | **Please check one** | **Notes** |
| History hoarding | Yes  No | Click or tap here to enter text. |
| Paranoid ideations | Yes  No | Click or tap here to enter text. |
| Wandering | Yes  No | Click or tap here to enter text. |
| Requires wander guard | Yes  No | Click or tap here to enter text. |
| Required locked unit for exit seeking | Yes  No | Click or tap here to enter text. |
| Requires 24/7 supervision/”sitter” for safety and risk | Yes  No | Click or tap here to enter text. |
| Requires private room due to behaviours | Yes  No | Click or tap here to enter text. |
| Requires bed alarms or wheelchair alarms in the community (as opposed to due to hospital policy) | Yes  No | Click or tap here to enter text. |
| Requires full bed-rails due to unsafe bed exiting behaviours | Yes  No | Click or tap here to enter text. |
| Broda-chair required for passive restraint | Yes  No | Click or tap here to enter text. |
| Suicide-ideation | Yes  No | Click or tap here to enter text. |
| Suicide-attempts | Yes  No | Click or tap here to enter text. |
| Self-harm | Yes  No | Click or tap here to enter text. |
| Aggression – physical | Yes  No | Click or tap here to enter text. |
| Aggression – verbal | Yes  No | Click or tap here to enter text. |
| Fire setting | Yes  No | Click or tap here to enter text. |
| Careless smoking | Yes  No | Click or tap here to enter text. |
| Assault – sexual | Yes  No | Click or tap here to enter text. |
| Assault –physical | Yes  No | Click or tap here to enter text. |
| Destruction of property | Yes  No | Click or tap here to enter text. |
| Sexual acting out | Yes  No | Click or tap here to enter text. |
| Other behaviours that may impact transition | Yes  No | Click or tap here to enter text. |

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| **Functional Status** | | **Comments/Notes/Remarks** |
| Bed Mobility | Independent  Requires supervision  One-person assistance  Two-person assistance  Able to identify need for reposition  Frequency of Reposition:Click or tap here to enter text. | Click or tap here to enter text. |
| Weight-Bearing | Cannot weight bear:  Right:  leg  arm  Left:  leg  arm | (i.e., plan, appointments) Click or tap here to enter text. |
| Transfer | Independent  Requires supervision  One-person assistance  Two-person assistance  Mechanical Lift – Hoyer  Mechanical Lift – Sit to Stand Lift  Uses Saska-pole  Bed-bound | Does the client have the equipment? Click or tap here to enter text. |
| Sitting Tolerance | No Limitations  Limited | Click or tap here to enter text. |
| Mobility | Independent with no aid  Independent with mobility aid  Supervision with mobility aid  Light hands on assistance with or  without a mobility aid  Dependent with mobility aid  **Mobility Aid Used by Client:**  Cane  Crutches  2-wheeled Walker  Rollator Walker  Other Walker Click or tap here to enter text.  Manual wheelchair  ☐ Power wheelchair  Width of Wheelchair Click or tap here to enter text.  **Stairs**  ☐Independent  ☐Supervision required  ☐Light assistance  ☐Unable  Stairs at discharge destination:  ☐Yes ☐No | Does the client have the equipment?Click or tap here to enter text. |
| Nutrition – Eating and Diet (see cooking later in list for those details) | **Feeding**  Independent eating  Requires cueing assistance/set up  Dependent  Can family feed dependent patient or  fund outside staff to do feeding  **Dentition**  Full  Partial  Difficulty chewing  Difficulty swallowing  **Diet Type**  Low protein  Renal  Raw Sodium  Other  **Diet Texture**  Needs thickened liquids  Needs modified textures for food  **Diet/Intake**  Gastronomy tubes (no NGs)  Dietary restrictions  Food Allergies  TPN  IV Fluids  Other (Please explain in notes)  **Preferred diet**  ☐Vegan  ☐Vegetarian  ☐Other | Explain unique diet and feeding needs:Click or tap here to enter text. |
| \*Please note, patient will need to have all their own specialty feeding supplies and equipment |
| Dressing/Grooming | **Upper Extremity**  Independent  Requires supervision/assistance  Cueing  Reluctant  Dependent  **Lower Extremity**  Independent  Requires supervision/assistance  Cueing  Reluctant  Dependent | Click or tap here to enter text. |
| Bathing | Independent  Requires supervision/assistance  Cueing  Reluctant  Dependent | Assistive Devices**:** Click or tap here to enter text. |
| Toileting – Bladder | **Continent**  Independent  Assistance require due to transfer/  mobility  Assistance with set-up (bed-pan,  urinal, commode)  **Incontinent**  Independent with brief changes  Dependent for brief changes  **Catheter Use**  Independent  Dependent  **Catheterization Needs**  Please include size/type.  In/out catheter  Indwelling  Condom catheter  Leg-bag  Bladder Scans | Incontinence status and plan at transfer (catheter in-situ, date needs to be changed etc.)Click or tap here to enter text. |
| \*Please note, patient will need to have their own incontinence or catheter supplies |
| Toileting – Bowels | **Continent**  Independent  Assistance required due to transfer/  mobility/ reach challenges  **Incontinent**  Independent with brief changes  Dependent for brief changes  **Bowel Routine with:**  Digital Stimulation  Enema  Suppository  **Ostomy**  Independent  Requires supervisions/assistance  Dependent | Incontinence status and plan at transfer (day ostomy last changed etc.) Click or tap here to enter text. |
| \*Please note, patient will need to have all their own incontinence or ostomy supplies. |
| Medicatiion | Independent  Requires medication reminders  Requires administration of oral meds  Requires administration of injections  Requires administration of IV meds  Requires PRN medications | For injections and IV, please clarify what will be administered and route (IV line, butterfly catheter etc.). Click or tap here to enter text. |
| \*Family will need to make arrangements for all medications and administration supplies before transition |
| iADLs – House cleaning | Independent  Requires some assistance  Requires substantial assistance  Not a pre-admit responsibility | Click or tap here to enter text. |
| iADLs – Cooking | Independent  Requires some assistance  Requires substantial assistance  Not a pre-admit responsibility  Supporters could provide meals if RCU does not provide meals  Willing to consider meals-on-wheels for meals | Click or tap here to enter text. |
| iADLs – Shopping | Independent  Requires some assistance  Requires substantial assistance  Not a pre-admit responsibility | Click or tap here to enter text. |
| iADLS – Finance | Independent  Requires some assistance  Requires substantial assistance  Not a pre-admit responsibility | Click or tap here to enter text. |
| iADLs – Transportation | Independent  Requires some assistance  Requires substantial assistance | \*Please note, family will be responsible for transportation to and from appointment while in RCU for ReCharge, the need will need to be explored  Click or tap here to enter text. |

**Comments/Other Details:** Click or tap here to enter text.

**Section 8: 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.

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| Reviewed with: | Click or tap here to enter text. | Relationship to patient, if not patient: | Click or tap here to enter text. |

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| Reviewed by: | Click or tap here to enter text. | Title: | Click or tap here to enter text. |

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| Date (dd/mm/yyyy): | Click or tap here to enter text. |

If you have any questions or concerns about this form, we welcome your feedback, please contact the CRM Team.