**\*\*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: |  |  |

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 (preferred) or Fax 365-300-5758 and 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: | \_ | Referrer’s Title: |  |
| Organization: |  | Unit Client is on: |  |
| Phone Number of Referring Contact: |  | E-mail Address of Referring Contact: |  |
| Date of Referral:(dd/mm/yyyy) |  | Preferred communication method: | [ ] Telephone[ ]  Email  |
| **SECTION 2: GENERAL PATIENT INFORMATION** |
| First Name and Middle Initial: |  | Last Name: |  |
| Date of Birth:(dd/mm/yyyy) |  | Gender Identity: | [ ]  He/Him [ ]  She/Her [ ]  They/Them |
| Gender | [ ]  Male [ ]  Female [ ]  Other |
| Ontario health card number & version code |  | Planned Discharge Date:(dd/mm/yyyy) |  |
| Telephone number: |  | E-mail Address:  |  |
| Pre-admit Address: |  |
| Did/does this client live alone at this address: [ ]  Yes [ ]  No |
| Does this person speak English? | [ ]  Yes [ ]  No | Is interpreter required? |  [ ]  Yes [ ]  NoLanguage:  |
| 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: Relationship: Phone: [ ]  POA [ ]  SDM [ ]  PGT |

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

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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 [ ]  NoDate: | Has the patient been designated at high risk for ALC: |  [ ]  Yes [ ]  No |
| Why does the caregiver/patient need ReCharge services at this time: |  |
| Why does the patient need a Reintegration Care Unit (RCU) at this time/ what are the goals for the RCU stay:  |  |
| 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: |  |
| 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.  |
| If this is not the client’s pre-admit home, please provide some info. on where they were living and why they cannot return: |  |
| 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 |  |

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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) |  |
| Consent given to share RAI: |  [ ]  Yes [ ]  No | Assessment Attached? |  [ ]  Yes [ ]  No |
| Assessment on IAR? |  [ ]  Yes [ ]  No |
| RAI Assessment Outcomes Scores: | MAPLe:  | CHESS:  | ADL:  | IADL:  | CPS:  | DRS:  |
| **SECTION 7: HEALTH STATUS (PHYSICAL HEALTH, MENTAL HEALTH AND/OR SUBSTANCE ABUSE)** |
| Height: |  | Allergies: None [ ]  |
| Weight: |  |
| Infectious Risks | Lice/Scabies [ ] MRSA [ ] VRE [ ] TB [ ] C. Diff [ ] Recent Respiratory Infection [ ]  Isolation Required: [ ]  Yes [ ]  NoNone [ ]  |
| Falls Risk |  [ ]  Yes [ ]  No# of falls in last 2 weeks: Last Fall:STRATIFY or Hendrich Score if available: | VisionFunctional [ ]  Impaired [ ]  Aids Used[ ]  |
| HearingFunctional [ ]  Impaired [ ]  Aids Used[ ]  |
| Diagnosis – Please include physical AND/OR mental health: |  |
| Brief Past Medical, Cognitive and/or Mental History. Please include consult notes. |  |
| 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. |
| 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):  |
| \*\*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: Hemodyalisis – Details: Rehab – PT, OT etc.- Details: Other.: |
| Palliative Care | Does the client have a palliative diagnosis: [ ]  Yes [ ]  NoIf yes,[ ] Estimated prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Advanced Directives (please attach a copy of DNRs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] EMS Provincial Sheet done (please attach a copy)[ ] Resources and Supports who will follow: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Special Needs that may impact transitions: | [ ] Oxygen specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*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 [ ]  NoDetails/Plan: |
| 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  |
|  |
| \*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 |  |
| Able to express their needs (i.e. hot, cold, tired) |  [ ]  Yes [ ]  No |  |
| Able to follow instructions |  [ ]  Yes [ ]  No |  |
| Memory challenges – short term |  [ ]  Yes [ ]  No |  |
| Memory challenges – long term  |  [ ]  Yes [ ]  No |  |
| Carry-Over/New Learning |  [ ]  Yes [ ]  No |  |
| Impaired Judgment impacting safety |  [ ]  Yes [ ]  No |  |
| Poor Insight into personal care needs |  [ ]  Yes [ ]  No |  |
| Managing medication |  [ ]  Yes [ ]  No |  |
| Able to participate in group settings |  [ ]  Yes [ ]  No |  |
| Other cognitive issues that may impact transition |  [ ]  Yes [ ]  No |  |
| If cognitively impaired, please include any formal assessment scores such as MOCA/MMSE/RUDAS |  |
| **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 |  |
| Paranoid ideations |  [ ]  Yes [ ]  No |  |
| Wandering |  [ ]  Yes [ ]  No |  |
| Requires wander guard |  [ ]  Yes [ ]  No |  |
| Required locked unit for exit seeking |  [ ]  Yes [ ]  No |  |
| Requires 24/7 supervision/”sitter” for safety and risk |  [ ]  Yes [ ]  No |  |
| Requires private room due to behaviours |  [ ]  Yes [ ]  No |  |
| Requires bed alarms or wheelchair alarms in the community (as opposed to due to hospital policy) |  [ ]  Yes [ ]  No |  |
| Requires full bed-rails due to unsafe bed exiting behaviours |  [ ]  Yes [ ]  No |  |
| Broda-chair required for passive restraint |  [ ]  Yes [ ]  No |  |
| Suicide-threats |  [ ]  Yes [ ]  No |  |
| Suicide-attempts |  [ ]  Yes [ ]  No |  |
| Self-harm |  [ ]  Yes [ ]  No |  |
| Aggression – physical |  [ ]  Yes [ ]  No |  |
| Aggression – verbal  |  [ ]  Yes [ ]  No |  |
| Fire setting |  [ ]  Yes [ ]  No |  |
| Careless smoking |  [ ]  Yes [ ]  No |  |
| Assault – sexual  |  [ ]  Yes [ ]  No |  |
| Assault –physical  |  [ ]  Yes [ ]  No |  |
| Destruction of property |  [ ]  Yes [ ]  No |  |
| Sexual acting out |  [ ]  Yes [ ]  No |  |
| Other behaviours that may impact transition |  [ ]  Yes [ ]  No |  |
| **Functional Status** | **Comments/Notes/Remarks** |
| Bed Mobility | [ ]  Independent[ ] Requires supervision[ ]  One-person assistance [ ]  Two-person assistance[ ]  Able to identify need for repositionFrequency of Reposition: |  |
| Weight-Bearing |  Cannot weight bear: Right: [ ]  leg [ ]  arm Left: [ ]  leg [ ]  arm | (i.e., plan, appointments)  |
| 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?  |
| Sitting Tolerance | [ ]  No Limitations[ ]  Limited |  |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Manual wheelchair☐ Power wheelchairWidth of wheelchair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Stairs**☐Independent☐Supervision required☐Light assistance☐UnableStairs at discharge destination: ☐Yes ☐No | Does the client have the equipment or any orthopedic devices? |
| 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 orfund 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 restrictionsFood Allergies[ ]  TPN [ ]  IV Fluids[ ]  Other (Please explain in notes)**Preferred diet** ☐Vegan☐Vegatarian☐Other | Explain unique diet and feeding needs: |
| \*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 |   |
| Bathing | [ ]  Independent[ ]  Requires supervision/assistance[ ]  Cueing[ ]  Reluctant[ ]  Dependent | Assistive Devices**:**  |
| 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.)  |
| \*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**Bowel Routine with:**[ ]  Digital Stimulation[ ]  Enema[ ]  Suppository**Incontinent**[ ]  Independent with brief changes[ ]  Dependent for brief changes**Ostomy**[ ]  Independent[ ]  Requires supervisions/assistance[ ]  Dependent | Incontinence status and plan at transfer (day ostomy last changed etc.)  |
| \*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.).  |
| \*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 |  |
| 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  |  |
| iADLs – Shopping | [ ]  Independent[ ]  Requires some assistance[ ]  Requires substantial assistance[ ]  Not a pre-admit responsibility |  |
| iADLS – Finance | [ ]  Independent[ ]  Requires some assistance[ ]  Requires substantial assistance[ ]  Not a pre-admit responsibility |  |
| iADLs – Transportation  | [ ]  Independent[ ]  Requires some assistance[ ]  Requires substantial assistance[ ]  Accessible transportation set up | \*Please note, family will be responsible for transportation to and from appointment while in RCU for ReCharge, the need will need to be explored |

**Comments/Other Details:**

**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: |  | Relationship to patient, if not patient: |  |

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| Reviewed by:  |  | Title: |  |

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| Date (dd/mm/yyyy): |  |

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