**\*\*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](mailto: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  No  Language: |
| 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  No  Date: | 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  No  None | | | | | | |
| Falls Risk | Yes  No  # of falls in last 2 weeks:  Last Fall:  STRATIFY or Hendrich Score if available: | | | Vision  Functional  Impaired  Aids Used | | | |
| Hearing  Functional  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  No  If 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  No  Details/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 reposition  Frequency 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 wheelchair  Width of wheelchair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Stairs**  ☐Independent  ☐Supervision required  ☐Light assistance  ☐Unable  Stairs 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 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  ☐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.