**\*\*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.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient First Name** |  | **Middle Name** |  | **Last 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** (this is NOT long-distance but a new local area code) the referral to Centralized Referral Management (CRM) for the RCM.
3. CRM Team to review the referral to determine **eligibility** for general RCU/ReCharge programs. If patient is eligible and all the info. is complete and clear, the patient will be **matched** to a Health Service Provider (HSP) who may be able to best meet their needs. You will receive a **confirmation emai**l within 1 business day (usually within hours) of that initial match and the next steps involved for that provider. If further information is required for better matching, we will reach out. Please feel free to call or email if you do not receive such an email or call.
4. For the RCU, the HSP will review the form and then they will reach out to you to proceed with individual detailed **intake assessment** process (varies from provider to provider). You, 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 – this will be communicated to you directly by the HSP Provider - but no further detailed applications will be needed.  For ReCharge, the HSP will reach out directly to the family post-discharge unless you indicate otherwise.  It is the individual HSP partners who will confirm if patient is **accepted.**
5. If after the intake assessment, your patient is deemed not a fit to the HSP they were matched to initially, the HSP will alert CRM Team, and the CRM Team will again review the referral, as well as consider the HSP and your thoughts on the first broken match. If possible, the patient will be **re-matched**.
6. You will be alerted and provided with a detailed explanation if: your patient is ineligible; there are barriers to matching; if there is going to be any delays in matching; or your patient is going to be on a waitlist.

Please contact CRM at **416-859-4376** or **647-326-1424** for further information or if you wish to consult with us prior to completing this referral. Office hours are 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 Patient 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** | | | |
| **Date of Birth:**  **(dd/mm/yyyy)** |  | **Gender Identity:** | He/Him  She/Her  They/Them |
| **Gender** | Male  Female  Other |
| **Ontario health card number** | **Must include version code** | **Planned Discharge Date:**  **(dd/mm/yyyy)** |  |
| **Telephone number:** |  | **E-mail Address:** |  |
| **Pre-admit Address:** |  | | |
| **Did/does this patient live alone at this address:**  Yes  No | | |

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| **SECTION 3: INFORMATION SHARING, COMMUNICATION AND LANGUAGE** | | | | | | |
| **Does this person speak English?** | | Yes  No | | **Is there First Language FRENCH?**  **\*\*There are sites specifically catering to French speaking patients\*\*** | | Yes  No |
| **Does the patient Speak another Language?** | | Yes  No  **Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Is an Interpreter Needed?** | | Yes  No |
| **Has this patient been deemed incapable of making personal care decisions?** | | | | Yes, formally assessed  Yes, hospital team opinion  No | | |
| **Vision**  **Functional  Impaired** | | **Aids Used:** | | **Hearing**  **Functional  Impaired** | | **Aids Used:** |
| **SECTION 4A: 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 4B: 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 5: 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 to prepare/plan/await their next community transition (home, new community housing, more supportive housing, other supportive environment 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, LOFT at White Squirrel Way, Reconnect Community Health Services, The Neighbourhood Group, Woodgreen Community Service and Centres D’Accueil Héritage | | | | | | | | | | | |
| **Clinical Care Reintegration Units (CCRU):** Hillcrest Reactivation Centre, Pine Villa SPRINT, Pine Villa LOFT, 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 patient in the community while promoting their own wellbeing. These specialized respite services include in- home day time respite, 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, Reconnect Community Health Services and Providence Healthcare | | | | | | | | | | | |
| **SECTION 6: 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 patient (including need for cleaning, equipment etc.) - must be achievable within the duration of the RCU max admit or shorter:** | | | |  | | | | | | | |
| **Confirmed with supports:  Yes  No** | | | |
| **Has Patient been in an RCU before and if yes, please provide details:**  **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**. | | | | | | | |
| **Could income impact transition? Does the patient have funds for their Post-RCU housing, equipment rental and medications:**  **Yes  No** | | | |  | | | | | | | |
| **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**  **Referral will not be processed if this info. is not included for patients going to LTC from RCU.** | | | | |  | | | | |
| **SECTION 7: HEALTH STATUS (PHYSICAL HEALTH, MENTAL HEALTH AND/OR SUBSTANCE ABUSE)** | | | | | | | | | | | |
| **Date of this Hospital Admit:** | | |  | | | **Previous Admit Date(s) if known:** | | | |  | |
| **Reason for Hospital Admit/Visit:** | | |  | | | | | | | | |
| **Brief Past Medical, Cognitive and/or Mental History. Please include consult notes if available.** | | |  | | | | | | | | |
| **Weight:**  **\*\*Required for patient needing Hoyer/2 person transfers** | | |  | | | **Height:** | | | |  | |
| **Allergies:**  **\*\*Please include the reaction. May include summary from patient’s chart but do indicate if info. is separate.**  **None** | **Food Allergies**:  **Drug Allergies**:  **Other Allergies:** | | | | | | | | | | |
| **Infectious Risks** | | | **Lice/Scabies**  **MRSA + :  Yes  No Colonized? :  Yes  No**  **VRE**  **TB**  **C. Diff**  **Recent Respiratory Infection**  **Isolation Required:  Yes  No**  **Flu Shot :  Yes  No**  **None** | | | | | | | | |
| **Falls Risk** | | | **Yes  No**  **# of falls in last 2 weeks:**  **Last Fall:**  **STRATIFY or Hendrich Score if available:** | | | | | | | | |
| **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:** | | | **Does patient need wound care:  Yes  No**  **\*\*Please include wound care orders from hospital and most recent wound care notes so we can ensure we can meet this need in RCU.**  **Does patient need any pressure relieving surfaces**  Yes  No  **Please provide details of the surface:**  **Can the patient/family/other fund the cost of these surfaces:  Yes  No** | | | | | | | | |
| **Planned follow-up post hospital discharge:**  **Yes  No** | | | **Chemotherapy – Details:**  **Hemodyalisis – Details:**  **Rehab – PT, OT etc.- Details:**  **Other.:**  \*\*RCUs do not provide transportation, assistance with arranging transport or portering for appointments | | | | | | | | |
| **Palliative Care** | | | **Does the patient 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 –patient self-managed and they have their own equipment**  **Tracheostomy –patient must be able to manage**  **Suctioning – long standing trach/suction – patient must be able to manage**  **Hemodialysis - patient/family must be able to arrange all transp**  **Peritoneal Dialysis – patient must be able to manage**  **Blood sugar testing**  **Methadone – Patient must be able to go out and get this on their own** | | | | | | | | |
| **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 patient 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 patient 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 |  |
| **Capable of new Learning/Carry-over of learning** | | Yes  No |  |
| **Impaired Judgment impacting safety** | | Yes  No |  |
| **Poor Insight into personal care needs** | | Yes  No |  |
| **Needs assistance 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 (patient 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 or Geri 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 only  One-person assistance  Two-person assistance  Mechanical Lift – Hoyer  Mechanical Lift – Sit to Stand Lift  Uses Saska-pole  Bed-bound | | **Does the patient 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 Patient:**  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 patient have the equipment or any orthopedic devices? RCUs do not provide mobility 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. |
| **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  High protein  Renal  Low Sodium  Other (please explain in notes)  **Diet Texture**  Needs thickened liquids (please explain)  Needs modified textures for food (please explain)  **Diet/Intake**  Gastronomy tubes (no NGs)  Dietary restrictions (please explain)  Food Allergies  TPN  IV Fluids  Other (Please explain in notes)  **Preferred diet**  Vegan  Vegetarian  Kosher  Gluten Free  Other (please explain in notes) | | **Explain unique diet and feeding needs. Please note that not all diet needs can be met in every RCU**s: |
| \*Please note, patient will need to have all their own specialty feeding supplies and equipment.  \*\*Patient may need to arrange their own foods at some sites. |
| **Medication** | 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 TO SHARE INFORMATION**

**\*\*Referral Source to review this with the patient or their designate (SDM, POA, PGT etc.)**

* Patient information contained within this form 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).

**Who is consenting to the sharing of Information (patient or other and their relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent Completed by (staff): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Form Completed by - list name and section completed if other then the Referrer:**

1.

2.

3.

4.

5.

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