STEPPING STONES REFERRAL AND FUNCTIONAL ASSESSMENT

CENTRALIZED REFERRAL MANAGEMENT
CRM is a division of Bellwoods.

The **Stepping Stone Project** (TSSP) at LOFT's John Gibson House in downtown Toronto, was launched in 2008 in partnership with the Centre for Addiction and Mental Health and Toronto's five downtown hospitals. The goal was to help address the challenges of transitioning seniors with history of mental health illness back to the community, who were medically ready for discharge, but no longer had an appropriate or safe discharge destination due to need for affordable and supportive housing. Twelve transitional units at John Gibson House were dedicated to this population, providing that supportive, affordable environment along with services that promoted the learning or relearning of the life skills they would need to live independently. The support is individualized, patient-centred and addresses the unique needs of the patient, allowing them to recover their dignity, independence and quality of life and prepare for their next community housing destination – some to complete independence, others do best in one of LOFT's seniors supportive housing programs and are transitioned there, and some become permanent residents of John Gibson House

FORM INSTRUCTIONS:

1. Please fill in all fields. Incomplete information will delay processing.
2. Use the latest version of this form from http://bellwoodscentres.org/centralized-referral-management/
3. Email completed form to mailto:crm.team@one-mail.on.ca(PREFERRED) or fax to 365-300-5758 (Toronto Area)
4. Get Detailed Instructions and help for this form here.

IF YOU ARE USING A COMPUTER-FILLABLE FORM, SAVE YOUR ANSWERS (FILE-SAVE)(CTRL-S ON WINDOWS)(COMMAND-S ON MAC)

Please contact CRM at **416-859-4376** or **647-326-1424** for further information. Office hours are from 8:30 am to 4:30 pm Monday to Friday.

REFERRAL PROCESS

1. **COMPLETE** ALL SECTIONS OF THIS FORM. MISSING INFORMATION COULD DELAY MATCHING.
2. **EMAIL** CRM.TEAM@ONE-MAIL.ON.CA OR FAX 365-300-5758 THE REFERRAL TO CENTRALIZED REFERRAL MANAGEMENT (CRM).
3. CRM TEAM WILL REACH OUT TO YOU WITHIN 1- 3 BUSINESS HOURS. YOU WILL BE PROVIDED WITH INFORMATION ON NEXT STEPS FOR EACH POSSIBLE OUTCOME – CONFIRMED INITIAL MATCH TO STTP; INELIGIBLE; WAITLISTED; OR DELAY MATCHING DUE TO NEED FOR ADDITIONAL INFORMATION. PLEASE FEEL FREE TO CALL OR EMAIL IF YOU DO NOT RECEIVE SUCH AN EMAIL OR CALL WITHIN 1 BUSINESS DAY.
4. THE REFERRAL WILL ONLY BE FORWARDED TO THE STTP TEAM ONCE A VACANCY HAS BEEN IDENTIFIED, PLEASE FEEL FREE TO CONNECT WITH THE CRM TEAM IF YOU REQUIRE INFORMATION ON THE WAITLIST OR IF THERE IS A NEED TO CANCEL THE REFERRAL.

1. PATIENT

FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH	GENDER (F/M/NON-BINARY)

PREADMIT ADDRESS	CITY	POSTAL CODE	LIVE ALONE?

HEALTH CARD NUMBER (WITH VERSION)	PLANNED DISCHARGE DATE

2. REFERRAL SOURCE INFORMATION

ORGANIZATION	YOUR NAME	TITLE	DATE

PHONE	EMAIL	CONTACT PREFERENCE

3. INFORMATION SHARING, COMMUNICATION, AND LANGUAGE

DOES THE PATIENT SPEAK ENGLISH?	IS THE PATIENT'S FIRST LANGUAGE FRENCH?* THERE ARE SITES SPECIFICALLY CATERING TO FRENCH-SPEAKING PATIENTS	IS AN INTERPRETER NEEDED?	LANGUAGE

HAS THE PATIENT BEEN DEEMED INCAPABLE OF MAKING PERSONAL CARE DECISIONS?

VISION	AIDS USED	HEARING	AIDS USED

4A. PRIMARY SUPPORT (FRIEND/FAMILY/OTHER)

FIRST NAME	LAST NAME	PHONE	RELATIONSHIP
EMAIL		DOES THIS PERSON LIVE WITH PATIENT?	

EMERGENCY CONTACTS OTHER THAN PRIMARY SUPPORT

1	NAME	CONTACT #	RELATIONSHIP
2	NAME	CONTACT #	RELATIONSHIP

4B. PROFESSIONAL CIRCLE OF CARE

PRIMARY DOCTOR (GP)	PHONE
PSYCHIATRIST	PHONE

OTHER SUPPORTS

✓		✓			
☐	BSS/BSTR	☐	HOME & COMMUNITY CARE	☐	SPECIALISTS: (LIST)
☐	CASE MANAGEMENT	☐	HOUSING WORKER	☐	OTHER (LIST):

CONTACT INFORMATION AND FOLLOW-UP APPOINTMENTS

5. ALC DESIGNATION & DISCHARGE DESTINATION

HAS THE PATIENT BEEN DESIGNATED ALC?	IF NO, IS PATIENT AT RISK FOR ALC? *PATIENT SHOULD BE ALC OR AT RISK FOR ALC TO QUALIFY FOR THIS PROGRAM

IF APPLYING FOR THE STEPPING STONE PROGRAM, WHAT DOES THE PATIENT NEED AT THIS TIME/ WHAT ARE THE GOALS FOR THE STAY?

EQUIPMENT RENTAL AND MEDICATIONS

COULD INCOME IMPACT TRANSITION OPTIONS		
IS EQUIPMENT NEEDED?		HOW IS IT FUNDED?
IS MEDICATION NEEDED?		HOW IS IT FUNDED?
DOES PATIENT NEED SUPPLIES? (G-tube, incontinence etc.)		HOW ARE THEY FUNDED?
HOW IS HOUSING FUNDED? (i.e. OW, ODSP, CCP, GIS, OAS etc.)		

HAS THE PATIENT APPLIED FOR LONG-TERM CARE AND HAS BEEN SELECTED	DATE OF LTC APPLICATION	**SUMMARY OF LTC CHOICES** (MANDATORY)
	IF CLIENT'S POST-RCU DESTINATION IS LTC, REFERRAL WILL NOT BE PROCESSED WITHOUT DETAILS OF ACCEPTED LTC AND EXPECTED WAIT TIMES AS OF DATE OF REFERRAL TO RCU	

6. HEALTH STATUS (PHYSICAL, MENTAL, AND/OR SUBSTANCE ABUSE)

DATE OF CURRENT HOSPITAL ADMIT	REASON	PREVIOUS 2 HOSPITAL ADMIT DATE IF KNOWN

BRIEF MEDICAL/COGNITIVE/MENTAL HEALTH HISTORY (A BRIEF OUTLINE IS REQUIRED ON THIS FORM, EVEN IF ADDITIONAL DOCUMENTATION PROVIDED WITH THE APPLICATION).

WEIGHT AND HEIGHT REQUIRED WHEN PATIENT NEEDS A HOYER OR 2-PERSON TRANSFER

WEIGHT:	HEIGHT:

ALLERGIES

☐ CONFIRMED NO ALLERGIES

**PLEASE INCLUDE THE REACTION. MAY INCLUDE SUMMARY FROM PATIENT'S CHART BUT INDICATE IF INFO IS SEPARATE.

FOOD ALLERGIES	DRUG ALLERGIES	OTHER ALLERGIES

INFECTIOUS RISKS

☐ ISOLATION REQUIRED ☐ C.DIFF ☐ RESPIRATORY INFECTION (RECENT) ☐ MRSA+

☐ TB ☐ VRE ☐ FLU SHOT ↘ IF YES HAS IT BEEN COLONIZED?

HISTORY OF INFESTATION

☐ NONE ☐ LICE/SCABIES ☐ BED BUGS ☐ OTHER:

FALLS RISK	# OF FALLS IN LAST 2 WEEKS & DATE OF LAST FALL	STRATIFY OR HENDRICH SCORE (IF AVAILABLE)

ACTIVE ADDITIONS	PROVIDE DETAILS INCLUDING SUBSTANCE AND ANY CURRENT TREATMENT ***ON-SITE USE OF ALCOHOL AND NON-PRESCRIBED DRUGS ARE PROHIBITED	SMOKER DOES PATIENT NEED AN ESCORT TO SMOKE?

IS WOUND CARE NECESSARY	PLEASE INCLUDE CURRENT WOUND CARE ORDERS

ARE PRESSURE RELIEVING SURFACES NECESSARY. IF YES PROVIDE DETAILS	SURFACE DETAILS
CAN PATIENT FUND THE COSTS OF THESE SURFACES	

POST-DISCHARGE PLANNED FOLLOW-UP

✓		DETAILS	✓		DETAILS
☐	CHEMOTHERAPY		☐	REHAB PT/OT/ETC.	
☐	HEMODYALISIS		☐	OTHER	

RCUs DO NOT PROVIDE TRANSPORTATION, ASSISTANCE WITH ARRANGING TRANSPORT OR PORTERING FOR APPOINTMENTS

DOES THE PATIENT HAVE A PALLIATIVE DIAGNOSIS? IF YES PROVIDE DETAILS	ESTIMATED PROGNOSIS ADVANCED DIRECTIVES EMS PROVINCIAL SHEET (ATTACH) RESOURCES AND SUPPORTS WHO FOLLOW

✓	OTHER SPECIAL NEEDS	✓	
	OXYGEN (FUNDING AND DELIVERY TO BE ARRANGED BEFORE TRANSITION)		METHADONE – PATIENT MUST BE ABLE TO GET THEIR OWN
	BIPAP/CPAP –PATIENT SELF-MANAGED WITH OWN EQUIPMENT		PERITONEAL DIALYSIS – PATIENT MUST BE ABLE TO MANAGE
	TRACHEOSTOMY –PATIENT MUST BE ABLE TO MANAGE		BLOOD SUGAR TESTING
	SUCTIONING – LONG STANDING TRACH/SUCTION – PATIENT MUST BE ABLE TO MANAGE		HEMODIALYSIS - PATIENT/FAMILY MUST BE ABLE TO ARRANGE ALL TRANSPORTATION

INCLUDE A DETAILED CURRENT MEDICATION LIST/MEDICATION ADMINISTRATION RECORD. MARK ANY RECENT MEDICATION CHANGES (MARK & DATE). A SIGNED MEDICATION LIST PRIOR TO DISCHARGE WILL BE REQUIRED.

ALTHOUGH ST. HILDA'S HILLCREST AND REKAI ARE CONNECTED TO PHARMACIES, PATIENTS MUST HAVE AT LEAST 24 HOURS OF MEDS AND SUBMIT FINAL MED LISTS 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

✓	COGNITIVE STATUS	NOTES
	ABLE TO DIRECT THEIR OWN CARE	
	ABLE TO EXPRESS THEIR NEEDS (I.E. HOT, COLD, TIRED)	
	ABLE TO FOLLOW INSTRUCTIONS	
	MEMORY CHALLENGES – SHORT TERM	
	MEMORY CHALLENGES – LONG TERM	
	CAPABLE OF NEW LEARNING/CARRY-OVER OF LEARNING	
	IMPAIRED JUDGMENT IMPACTING SAFETY	
	POOR INSIGHT INTO PERSONAL CARE NEEDS	
	NEEDS ASSISTANCE MANAGING MEDICATION	
	ABLE TO PARTICIPATE IN GROUP SETTINGS	
	OTHER COGNITIVE ISSUES THAT MAY IMPACT TRANSITION IF COGNITIVELY IMPAIRED, PLEASE INCLUDE ANY FORMAL ASSESSMENT SCORES SUCH AS MOCA/MMSE/RUDAS	

	BEHAVIOURAL STATUS (PATIENT SAFETY & RISK)	*NOTE: INCLUDE CURRENT AND BEHAVIOURS NOTED IN THE LAST 2 MONTHS
	HISTORY HOARDING	
	PARANOID IDEATIONS	
	WANDERING	
	REQUIRES WANDER GUARD	
	REQUIRED LOCKED UNIT FOR EXIT SEEKING	
	REQUIRES 24/7 SUPERVISION/"SITTER" FOR SAFETY AND RISK	

	REQUIRES PRIVATE ROOM DUE TO BEHAVIOURS	
	REQUIRES BED ALARMS OR WHEELCHAIR ALARMS IN THE COMMUNITY (AS OPPOSED TO DUE TO HOSPITAL POLICY)	
	REQUIRES FULL BED-RAILS DUE TO UNSAFE BED EXITING BEHAVIOURS	
	BRODA OR GERI CHAIR REQUIRED FOR PASSIVE RESTRAINT	
	SUICIDE-IDEATION	
	SUICIDE-ATTEMPTS	
	SELF-HARM	
	AGGRESSION – PHYSICAL	
	AGGRESSION – VERBAL	
	FIRE SETTING	
	CARELESS SMOKING	
	ASSAULT – SEXUAL	
	ASSAULT –PHYSICAL	
	DESTRUCTION OF PROPERTY	
	SEXUAL ACTING OUT	
	OTHER BEHAVIOURS THAT MAY IMPACT TRANSITION	

FUNCTIONAL STATUS

BED MOBILITY

☐ INDEPENDENT ☐ REQUIRES SUPERVISION ☐ ONE-PERSON ASSISTANCE ☐ TWO-PERSON ASSISTANCE

☐ ABLE TO IDENTIFY NEED FOR REPOSITION FREQUENCY OF REPOSITION:

WEIGHT-BEARING – CANNOT BEAR WEIGHT ON

☐ LEFT LEG ☐ RIGHT LEG

☐ LEFT ARM ☐ RIGHT ARM

RE-ASSESSMENT PLAN

TRANSFER

☐ ONE-PERSON ASSISTANCE ☐ USES SASKA-POLE ☐ MECHANICAL LIFT – HOYER

☐ TWO-PERSON ASSISTANCE ☐ BED-BOUND ☐ MECHANICAL LIFT – SIT TO STAND LIFT

DOES THE PATIENT HAVE EQUIPMENT?

SITTING TOLERANCE

MOBILITY

MOBILITY AID USED BY PATIENT:

☐ CANE ☐ CRUTCHES ☐ 2-WHEELED WALKER ☐ ROLLATOR WALKER ☐ OTHER WALKER ☐ MANUAL WHEELCHAIR ☐ POWER WHEELCHAIR

WIDTH OF WHEELCHAIR: ☐

STAIRS:

STAIRS AT DISCHARGE DESTINATION: ☐

DRESSING/GROOMING

✓ **UPPER EXTREMITY**

☐ CUEING
☐ RELUCTANT
☐ DEPENDENT

✓ **LOWER EXTREMITY**

☐ CUEING
☐ RELUCTANT
☐ DEPENDENT

BATHING

☐ CUEING
☐ RELUCTANT
☐ DEPENDENT

TOILETING-BLADDER

CONTINENT

☐ INDEPENDENT
☐ ASSISTANCE WITH TRANSFER/MOBILITY
☐ ASSISTANCE WITH SETUP(BED PAN, ETC)

INCONTINENT

CATHETER USE

CATHETERIZATION NEEDS

☐ 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.)

TOILETING-BOWELS

CONTINENT **BOWEL ROUTINE WITH:** **INCONTINENT** **OSTOMY**

PLEASE NOTE, PATIENT WILL NEED TO HAVE ALL THEIR OWN INCONTINENCE OR OSTOMY SUPPLIES

FEEDING

✓ FEEDING	✓ PREFERRED DIET	✓ REQUIRED DIET (PRESCRIBED)	✓ DENTITION/SWALLOW	✓ DIET/INTAKE
☐ INDEPENDENT	☐ NO PREFERENCE	☐ LOW PROTEIN	☐ FULL DENTITION	☐ GASTRONOMY TUBES (NO NGS)
☐ CUEING/ASSISTANCE/SETUP	☐ VEGAN	☐ HIGH PROTEIN	☐ PARTIAL DENTITION	☐ DIETARY RESTRICTIONS
☐ DEPENDENT	☐ VEGETARIAN	☐ RENAL DIET	☐ DIFFICULTY CHEWING	☐ **SPECIALITY INTAKE**
☐ FAMILY ASSIST DEPENDENT PATIENT	☐ KOSHER	☐ LOW SODIUM	☐ NEEDS MODIFIED TEXTURES	☐ TPN
	☐ GLUTEN FREE	☐ FOOD ALLERGIES (SEE LIST)	☐ DIFFICULTY SWALLOWING	☐ IV FLUIDS
			☐ CUEING FOR SWALLOWING	☐ G-TUBE
				☐ NG-TUBE

☐ OTHER (EXPLAIN BELOW)

ADDITIONAL NOTES

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

iADLS – COOKING

- ☐ SUPPORTERS COULD PROVIDE MEALS IF MEALS NOT PROVIDED
- ☐ WILLING TO CONSIDER MEALS-ON-WHEELS FOR MEALS

iADLS – SHOPPING

iADLS – FINANCE

iADLs – TRANSPORTATION

*Please note, family will be responsible for transportation to and from appointment while in RCU for ReCharge, the need will need to be explored

LEGAL HISTORY IS CLIENT CURRENTLY UNDER THE ORB?	FOBS CASEMANAGER	FOBS OUTPATIENT PSYCHIATRIST	INDEX OFFENCE

7. 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 according to the guidelines within the Ontario Personal Health Information Protection Act (PHIPA) with respect to the collection, use, disclosure, maintenance and disposal of personal health information (PHI).

WHO IS CONSENTING TO SHARE INFORMATION (ADD RELATIONSHIP TO PATIENT)	DATE OF CONSENT	CONSENT COMPLETED BY (NAME & ROLE OF STAFF)

8. FORM COMPLETED BY

1		4	
2		5	
3		6	