CAREGIVER RECHARGE SERVICE REFERRAL AND FUNCTIONAL ASSESSMENT

CENTRALIZED REFERRAL MANAGEMENT
CRM is a division of Bellwoods.

The **Short-Term Transitional Care Models** (STTCM) pilot project was launched in Fall of 2017 by the Toronto Central LHIN and funded by the Ministry of Health and Long-Term Care 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. The initiatives are needs based, time limited and with no additional fee for the programs.

The **Caregiver ReCharge Services** (CRS or ReCharge) is one of those initiatives, focusing on short-term caregiver relief to improve the carer/caregiver/supporter's capacity to help transition the patient home and continue to provide care for the patient in the community, while promoting the carers' own well-being. They include short-term In-Home Respite (30 hrs/month x 3 months) and short-term Adult Day Program spots. Neither program has a cost for the patient/carer. The ReCharge Providers are Bellwoods (Community Connect) and St. Clair O'Connor Community Centre.

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. E-MAIL 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 – MATCHED; 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 CRM TEAM WILL GLADLY CONTINUE TO WORK WITH YOU AND YOUR PATIENT UNTIL THE PATIENT IS ABLE TO BE MATCHED TO AN STTCM CAREGIVER RECHARGE SERVICE OR IS REDIRECTED APPROPRIATELY. PLEASE DO ALERT US 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)
			0000 00 00	-

PREADMIT ADDRESS	CITY	POSTAL CODE	LIVE ALONE?
			-

HEALTH CARD NUMBER (WITH VERSION)	PLANNED DISCHARGE DATE
	0000 00 00

2. REFERRAL SOURCE INFORMATION

ORGANIZATION	YOUR NAME	TITLE	DATE
			0000 00 00

PHONE	EMAIL	CONTACT PREFERENCE
		-

3. INFORMATION SHARING, COMMUNICATION, AND LANGUAGE

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

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?
	YES

EMERGENCY CONTACTS OTHER THAN PRIMARY SUPPORT

	NAME	CONTACT #	RELATIONSHIP
1			
2			

4B. PROFESSIONAL CIRCLE OF CARE

PRIMARY DOCTOR (GP)	PHONE

PSYCHIATRIST	PHONE

OTHER SUPPORTS

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

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

DATE OF CURRENT HOSPITAL ADMIT	REASON	PREVIOUS 2 HOSPITAL ADMIT DATE IF KNOWN
0000 00 00		

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
- ☐ TB
- ☐ C.DIFF
- ☐ VRE
- ☐ RESPIRATORY INFECTION (RECENT)
- ☐ FLU SHOT
- ☐ MRSA+
- ↘ IF YES HAS IT BEEN COLONIZED? ☐ YES ☐ NO

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	SMOKER
-	***ON-SITE USE OF ALCOHOL AND NON-PRESCRIBED DRUGS ARE PROHIBITED	- DOES PATIENT NEED AN ESCORT TO SMOKE? -

DOES THE PATIENT HAVE A PALLIATIVE DIAGNOSIS? IF YES PROVIDE DETAILS NO	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

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

DOES THE PATIENT HAVE MOBILITY EQUIPMENT?

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**

- ☐ INDEPENDENT
- ☐ CUEING/ASSISTANCE/SETUP
- ☐ DEPENDENT
- ☐ FAMILY ASSIST DEPENDENT
- ☐ PATIENT

✓ **PREFERRED DIET**

- ☐ NO PREFERENCE
- ☐ VEGAN
- ☐ VEGETARIAN
- ☐ KOSHER
- ☐ GLUTEN FREE

✓ **REQUIRED DIET (PRESCRIBED)**

- ☐ LOW PROTEIN
- ☐ HIGH PROTEIN
- ☐ RENAL DIET
- ☐ LOW SODIUM
- ☐ FOOD ALLERGIES (SEE LIST)

✓ **DENTITION/SWALLOW**

- ☐ FULL DENTITION
- ☐ PARTIAL DENTITION
- ☐ DIFFICULTY CHEWING
- ☐ NEEDS MODIFIED TEXTURES
- ☐ DIFFICULTY SWALLOWING
- ☐ CUEING FOR SWALLOWING

✓ **DIET/INTAKE**

- ☐ GASTRONOMY TUBES (NO NGS)
- ☐ DIETARY RESTRICTIONS
- ☐ **SPECIALITY INTAKE**
- ☐ TPN
- ☐ IV FLUIDS
- ☐ 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

iADLS – HOUSE CLEANING -

iADLS – COOKING -

- ☐ SUPPORTERS COULD PROVIDE MEALS IF RCU DOES NOT PROVIDE MEALS
- ☐ 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

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	DATE OF CONSENT	CONSENT COMPLETED BY (NAME & ROLE OF STAFF)
-		
IF OTHER ENTER RELATIONSHIP:	0000 00 00	

8. FORM COMPLETED BY

1		4	
2		5	
3		6	