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 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 416-447-1224 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)
			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
-	-

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)
-	0000 00 00	

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
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

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)
YES		

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? -

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

Independent With No Aid

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)
-	0000 00 00	

8. FORM COMPLETED BY

1		4	
2		5	
3		6	