REINTEGRATION CARE UNIT 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 **Reintegration Care Units** (RCUs) is one of those initiatives, providing patients with a short-term safe and supportive place to go post-hospital discharge with a focus on patient goals and needs for re-activation and engagement, while also allowing time to optimize, plan and prepare their next community transition (home, new community housing, more supportive housing, other supportive environments etc.). Patients do need to have a discharge destination to work towards at time of referral. RCU Providers are: Bellwoods (Community Connect); LOFT (White Squirrel Way and Pine Villa), Sprint (Pine Villa), Reconnect Community Health Services (Doug Saunders and 2 sites), Rekai Centres (Rekai Centres Transitional Care Unit), The Neighbourhood Group (various independent units) and UHN (Hillcrest Reactivation Centre and St. Hilda's Transitional Care Program). There is also a provider for French speaking patients with Centres D'Accueil Héritage.

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@bcclsp.org (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 by email or by calling **416-447-1224** 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@bcclsp.org 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 MOVE TO RCU OR ALL OPTIONS FOR RCU ARE EXHAUSTED. PLEASE DO ALERT US IF THERE IS A NEED TO CANCEL THE REFERRAL.

Please contact CRM at 416-447-1224 or further information or if you wish to consult with us prior to completing this referral. Office hours are from 8:30 am to 4:00 pm Monday to Friday

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? -	

EMERGENCY CONTACTS OTHER THAN PRIMARY SUPPORT

	NAME	CONTACT #	RELATIONSHIP
1			
2	NAME	CONTACT #	RELATIONSHIP

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 AN RCU TRANSITIONAL BED, WHY DOES THE PATIENT NEED AN RCU AT THIS TIME/ WHAT ARE THE GOALS FOR THE RCU STAY?

HAS PATIENT BEEN IN AN RCU BEFORE (PROVIDE DATE & DETAILS)

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.)?

PLAN CONFIRMED WITH SUPPORTS?

-

PLAN MUST BE ACHIEVABLE WITHIN THE DURATION OF THE RCU MAX ADMIT

LIST POTENTIAL ENVIRONMENTAL BARRIERS THAT MAY IMPACT TRANSITION TO THIS LOCATION (I.E. STAIRS, LIP TO DOORWAY, BATHROOM ON ANOTHER FLOOR) AND PROVIDE ANY INFO. ON PLAN TO ADDRESS THESE.	NO. OF STAIRS

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 ☐ C.DIFF ☐ RESPIRATORY INFECTION (RECENT) ☐ MRSA+
☐ TB ☐ VRE ☐ FLU SHOT ↘ 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? -

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 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

✓	**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

WIDTH OF WHEELCHAIR:

DOES THE PATIENT HAVE MOBILITY EQUIPMENT? -

STAIRS:

-

STAIRS AT DISCHARGE DESTINATION: ☐

DRESSING/GROOMING

✓ **UPPER EXTREMITY**	✓ **LOWER EXTREMITY**	**BATHING**
-	-	-
☐ CUEING	☐ CUEING	☐ CUEING
☐ RELUCTANT	☐ RELUCTANT	☐ RELUCTANT
☐ DEPENDENT	☐ DEPENDENT	☐ 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 RCU DOES NOT PROVIDE MEALS
☐ WILLING TO CONSIDER MEALS-ON-WHEELS FOR MEALS

iADLS – SHOPPING -

iADLS – FINANCE -

iADLs – TRANSPORTATION -

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	