REINTEGRATION CARE UNIT REFERRAL AND FUNCTIONAL ASSESSMENT

CENTRALIZED REFERRAL MANAGEMENT
CRM is a division of Bellwoods.

The **Reintegration Care Units** (RCUs) is one of the Transitional Care Programs created 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 RCUs provide 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 for their next community transition (home, new community housing, supportive housing, other supportive environments etc.). Due to the transitional nature of the program, patients will need to have a discharge destination to work towards at time of referral.

The RCU Providers include:

1. Bellwoods
2. LOFT (White Squirrel Way and Pine Villa),
3. Pine Villa SPRINT
4. Reconnect Community Health Services (Doug Saunders and 2 other sites)
5. The Neighbourhood Group (various independent units)
6. Hillcrest Reactivation Centre
7. UHN Transitional Care Program at Queen's Estate
8. Centres D'Accueil Héritage- French speaking patients

REFERRAL PROCESS

1. Complete **ALL** sections of this form. Missing information could delay matching.
2. Submit the completed referral form to Centralized Referral Management (CRM) via **E-MAIL** at crm.team@bcclsp.org (PREFFERED) OR **FAX to 365-300-5758** (TORONTO AREA)
3. The CRM Team will reach out to you within 3 business hours and you will be **provided with information on the next steps** for each possible outcome- Matched, Ineligible, Wait-listed, or a Delay in matching due to a 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 **continue to work** with you and your patient until the patient is able to move to an RCU or until all options for RCU are exhausted. Please alert us if there is a need to cancel the referral.

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

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

EXCLUSION CRITERIA

The CRM team understands the uniqueness of each case and will make every attempt to explore all options for your patient. Despite this, there are instances where a candidate may be deemed unsuitable for the RCU program. These include:

1. Patients without OHIP coverage.
2. Referrals submitted by an out of region hospital. Please feel free to connect with us to determine whether your hospital is one of the approved hospitals in the RCU network.
3. Patients who require hands on feeding support **AND** are at high risk for aspiration. (There are limited spaces for patients who require feeding support who are **NOT** at high risk for aspiration).
4. Patients with no PSW or Nursing needs, with no other goals aside from temporary housing.
5. Patients who require any form of restraints (passive, chemical, etc.)
6. Patients who require a Broda chair, Tilt-chair or Lap-belt for **passive restraint.**
7. Specialized technology dependent (e.g. Mechanical ventilation, TPN, patient controlled analgesia, etc.)
8. Patients who require close physician monitoring (i.e. for pain or complex symptom management or regular medication adjustments/changes in care based on presentation).
9. Specialized care needs- e.g. Tracheostomy, NJ Tubes.
10. Uncontrolled/Poorly managed physical behaviours. Patients with a history of behaviours can be considered on a case by case basis if the behaviours become stable**

**CRM can connect our hospital partners with the LOFT Behaviour Support Transition Resource (BSTR) team (where applicable) if assistance with behavioural support and the creation of a support plan is required to facilitate possible RCU transition.

Kindly note that this program and it's related policies are dynamic. Thus, this information is subject to change. Additionally, depending on the case there may be additional barriers to RCU admission that have not been identified in the list above.

1. PATIENT

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

PREADMIT ADDRESS	CITY	POSTAL CODE	LIVE ALONE?	PHONE NUMBER
			-	

HEALTH CARD NUMBER (WITH VERSION)	PLANNED HOSPITAL DISCHARGE DATE
	0000 0 0

2. REFERRAL SOURCE INFORMATION

ORGANIZATION	YOUR NAME	TITLE	DATE (YYYY/MM/DD)
			0000 0 0

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	ALC DATE (YYYY/MM/DD)
-	-	

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

- ☐ AWAIT AN LTC BED OFFER
- ☐ AWAIT REHAB (REHAB ACCEPTANCE IS REQUIRED)
- ☐ RECOVERY FROM ILLNESS/INJURY/SURGERY
- ☐ AWAIT HOME RENOVATIONS/MODIFICATIONS (PROVIDE DETAILS BELOW, E.G TYPE OF RENOVATIONS, TIMEFRAME, ETC.):
- ☐ AWAIT HOME DEEP CLEAN
- ☐ TEMPORARY HOUSING ONLY
- ☐ INCREASE ENDURANCE/STRENGTH/ CONFIDENCE WITH ADLS
- ☐ AWAIT SURGERY
- ☐ OTHER (PLEASE SPECIFY & PROVIDE DETAILS BELOW):

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.)?

- ☐ NO DISCHARGE DESTINATION
- ☐ LTC
- ☐ REHAB
- ☐ HOME
- ☐ OTHER, PLEASE SPECIFY BELOW:

- ☐ RETIREMENT HOME
- ☐ SHELTER
- ☐ DISCHARGE PLAN IN MOTION (UNCONFIRMED)
- ☐ SUPPORTIVE HOUSING
- ☐ SURGERY:

SURGERY DATE: _____

SURGERY LOCATION: _____

DETAILS CONFIRMED? - ____

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

HAS THE PATIENT APPLIED FOR LONG-TERM CARE	DATE OF LTC APPLICATION (YYYY/MM/DD)	**REQUESTING A SUMMARY OF ALL LTC CHOICES & ACCEPTANCES** (MANDATORY)
-	0000 0 0	

IF CLIENT'S POST-RCU DESTINATION IS LTC, REFERRAL WILL NOT BE PROCESSED WITHOUT DETAILS OF ACCEPTANCES

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

DATE OF CURRENT HOSPITAL ADMIT	REASON	PREVIOUS 2 HOSPITAL ADMIT DATES IF KNOWN (YYYY/MM/DD)
0 0		

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

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, REASON: _____
- ☐ ISOLATION PRECAUTION REQUIRED (SPECIFY TYPE BELOW):
- ☐ C.DIFF
- ☐ VRE
- ☐ COVID OUTBREAK ON SITE?
- ☐ CLIENT VACCINE COMPLETE
- ☐ MRSA+, COLONIZED
- ☐ MRSA+, NOT COLONIZED

**PLEASE ATTACH IPAC NOTES IF ISOLATION IS REQUIRED

HISTORY OF INFESTATION

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

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 INCLUDING **PPS SCORE**	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
☐	TRACHEOSTOMY	☐	BLOOD SUGAR TESTING
☐	SUCTIONING – LONG STANDING TRACH/SUCTION – PATIENT MUST BE ABLE TO MANAGE	☐	HEMODIALYSIS - PATIENT/FAMILY MUST BE ABLE TO ARRANGE ALL TRANSPORTATION

IS WOUND CARE NECESSARY? - IS VAC THERAPY REQUIRED? -	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 -	

✓	**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	
☐	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	

	RESPONSIVE BEHAVIOURS	*NOTE: INCLUDE CURRENT AND BEHAVIOURS NOTED IN THE LAST 2 MONTHS
☐	HISTORY OF HOARDING	
☐	PARANOID IDEATIONS	
☐	WANDERING	
☐	REQUIRES LOCKED UNIT FOR EXIT SEEKING	
☐	REQUIRES 24/7 SUPERVISION/ "OBSERVER" 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	
☐	OTHER BEHAVIOURS THAT MAY IMPACT TRANSITION	

ACTIVE ADDICTIONS BEFORE HOSPITAL ADMIT? - IS THE PATIENT CONNECTED WITH SUPPORTS? -	PROVIDE DETAILS INCLUDING SUBSTANCE AND ANY CURRENT TREATMENT	SMOKER - DOES PATIENT NEED AN ESCORT TO SMOKE? -

WHAT BEHAVIOURS ARE ASSOCIATED WITH THE PATIENT'S SUBSTANCE USAGE AND HOW OFTEN ARE THESE SUBSTANCES SOURCED?

**PLEASE ATTACH ADDICTIONS MANAGEMENT PLAN

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? -

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

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 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

☐ OTHER (EXPLAIN BELOW)

✓ **PREFERRED DIET**

☐ NO PREFERENCE

☐ VEGAN

☐ VEGETARIAN

☐ KOSHER

☐ GLUTEN FREE

✓ **REQUIRED DIET (PRESCRIBED)**

☐ LOW PROTEIN

☐ HIGH PROTEIN

☐ RENAL DIET

☐ LOW SODIUM

✓ **DENTITION/SWALLOW**

☐ FULL DENTITION

☐ PARTIAL DENTITION

☐ DIFFICULTY CHEWING

☐ NEEDS MODIFIED TEXTURES

☐ DIFFICULTY SWALLOWING

☐ CUEING FOR SWALLOWING

✓ **DIET/INTAKE**

☐ GASTRONOMY TUBES (NO NGS)

☐ DIETARY RESTRICTIONS

☐ NG- TUBE

☐ TPN

☐ IV FLUIDS

☐ G-TUBE

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 IV MEDS
- ☐ REQUIRES PRN MEDICATIONS
- ☐ REQUIRES ADMINISTRATION OF INJECTIONS

HOW WILL THE MEDICATIONS BE FUNDED? (NOTE: MEDICATION IS NOT COVERED BY THE RCUS) _____

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 **SOME RCUS** ARE CONNECTED TO PHARMACIES, PATIENTS MUST HAVE AT LEAST 24 HOURS OF MEDS AND SUBMIT THE FINAL MED LISTS BY 3PM THE DAY BEFORE ADMIT. ALL OTHER RCUS REQUIRE THE PATIENT TO COME WITH THEIR OWN MEDICATION WITH A PLAN ON HOW THEY WILL GET MORE FOR THE DURATION OF THE STAY

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 Models (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 (YYYY/MM/DD)	CONSENT COMPLETED BY (NAME & ROLE OF STAFF)
-	0000 0 0	

8. FORM COMPLETED BY

1		4	
2		5	
3		6	