Discharge Referral Form

Home at Last

HOSPITAL ADDRESSOGRAPH

HRRH, NYGH, SJRH
Fax: 1-888-825-9622
Tel: 647-404-1411

MH, MSH, SM, SRHC
Fax: 905-713-1841
or 1-877-676-0666
Tel: 1-866-291-1503

Please call before faxing this referral

I. CONSENT

Referral discussed with client? ☐ YES ☐ NO	Verbal consent given to collect, use and disclose information for transmission of referral? ☐ YES ☐ NO – *DO NOT PROCEED WITH REFERRAL*
Verbal consent given to discuss referral with substitute decision maker? ☐ YES ☐ NO	Consent given by: _____ Phone No.: _____ Relationship to client: _____

II. REFERRAL SOURCE INFORMATION

Date of Referral: _____	Referring Hospital: _____	
Hospital Contact Name: _____	Title: _____	Phone/Pager#: _____
Reason for Hospitalization: _____	CHECK ONE: ☐ Inpatient ☐ ED	
Follow Up to Referral Required? ☐ YES ☐ NO	Current CCAC Client? ☐ YES ☐ NO	CCAC CONTACTED? ☐ YES ☐ NO

III. CLIENT INFORMATION

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Other	

English Spoken? : ☐ YES ☐ NO Client's preferred Language: _____ Other languages: _____

IV. GENERAL MEDICAL CONDITION CHECK LIST

MOBILITY: ☐ Independent ☐ Unable to climb stairs ☐ Requires wheelchair ☐ Requires mobility aid: _____

☐ Allergies (food, medication, other): _____	☐ Arthritis	☐ Renal
☐ Isolation Precautions: _____	☐ Cardiovascular	☐ Requires O2 in the home
☐ Cognitive Status: _____	☐ Diabetes	☐ Has portable O2 tank with them
☐ Alzheimer's disease and related dementias	☐ Infection	☐ Other: _____

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Client Name: _____
D.O.B.: _____

I. DOES THE PATIENT MEET HAL ELIGIBILITY CRITERIA?	
☐ **YES** - 65+, stable condition, client and/or caregiver able to direct own care, can manage with 1 person transfer, special circumstance	☐ **NO** - explain exceptional circumstances: _____

II. HOSPITAL DISCHARGE INFORMATION	☐ ED	☐ Inpatient
Discharge Date: _____	**Discharge Time:** _____	**Unit/Room#:** _____

III. HAL CORE SERVICES INCLUDE

- **Personal Support Worker settling-in service**
- **Personal Support Worker in-home safety assessment**
- **HAL Coordinator follow-up call to client and referrals to other community services as required**

IV. HAL OPTIONAL SERVICES - SELECT SERVICE(S)		COMMENTS/ADDRESS
☐ **Transportation Home**	☐ *Able to be transferred to HAL vehicle by walking with one person assist or using a wheelchair* ☐ *Wheelchair Accessible Vehicle (subject to availability)*	
☐ **Medication Pick Up**	☐ *Prescription Provided to Patient* ☐ *Prescription Forwarded to Pharmacy*	
☐ **Medical Supplies Pick Up**		
☐ **Grocery Pick Up**		
☐ **Same Day Meal – Frozen Meal**	**Special Diet**: _____	

V. DESTINATION ADDRESS: USE ONLY IF DIFFERENT THAN HOSPITAL ADDRESSOGRAPH

No. and Street name: _____ **Tel. no.** _____ **Apt.** _____ **City:** _____

VI. ENVIRONMENTAL FACTORS

☐ **Lives Alone** ☐ **Pets** ☐ **Smoker** **Comments:** _____

Entrance Details: ☐ Front ☐ Back ☐ Elevator ☐ Stairs

VII. PATIENT ITEMS		
Keys Available? ☐Yes ☐No	**Clothing/Shoes Available?** ☐Yes ☐No	**Money Available for Pick Up Items Listed Above?** ☐Yes ☐No

VIII. FAMILY OR CAREGIVER CONTACT INFORMATION (IF APPLICABLE)		
Name: _____	**Phone#:** _____	**Relationship:** _____
Lives with Patient? ☐Yes ☐No	**Contacted?** ☐Yes ☐No **Comments:** _____	

IV. ADDITIONAL INFORMATION – please provide any additional information that would help the HAL worker settle in the patient

_____

_____

_____

Note to Hospital Staff: If you wish to follow up with the client, please do so directly.