HOME AND COMMUNITY CARE SUPPORT SERVICES
Hamilton Niagara Haldimand Brant

Long-Term Care Home Referral for Services

To accompany ALL requests for Nursing, Wound Care Specialist or Speech Language Pathologist for Swallowing Assessment

Contact HCCSS HNHB at **1-800-810-0000** Fax: 905-639-8704 or 1-866-655-6402

Patient Name_____ HCN_____ VC_____ DOB_____
Facility and Address_____ City_____
Ward_____ Room_____ Facility Phone_____

PATIENT INFORMATION

Is the patient competent to make treatment decisions? ☐Yes ☐No If no, see below:

NOTE: Substitute Decision Maker (SDM) must be able to make treatment decisions.
SDM Name:_____
SDM Contact #:_____ Date Notified: dd/mm/yyyy

Consent Given? ☐Yes ☐No ***If no – do not send referral****
SDM wishes to be present for assessment/consultation? ☐Yes ☐No
Is English the patient's preferred language? ☐Yes ☐No
If no, what language does the patient understand:_____
Does the patient use a communication aid? ☐Yes ☐No Specify:_____

Other Concerns: ☐MRSA ☐VRE ☐C diff ☐Other:_____
Is the LTC home currently in outbreak? ☐Yes ☐No Is the outbreak on patient's unit/floor? ☐Yes ☐No

SERVICE REQUESTED

☐ **Speech Language Pathology**

Present Diet Texture:_____ Fluid:_____
Reason for Referral_____

Patient is unable to access services outside the home i.e. outpatient clinic due to their condition? ☐Yes ☐No
Has patient been assessed by your dietician? ☐Yes ☐No ***(include dietitian interventions & consult notes with referral)***
Swallowing assessment recommended by clinician? ☐Yes ☐No Referred by: ☐Dietician ☐MD ☐Nurse
Have directives left by SLP previously been followed? ☐Yes ☐No Specify:_____
Does patient have a weight loss in the past 2 months? ☐Yes ☐No Amount:_____
Describe patient's intake/appetite: ☐Good ☐Fair ☐Poor
Is there a history of aspiration, congestion and/or pneumonia? ☐Yes ☐No Specify:_____
Is the patient "pocketing" food? (i.e. food/residue remains in mouth after a swallow) ☐Yes ☐No
Is the patient a self-feeder? ☐Yes ☐No
Is the patient able to follow directions? ☐Yes ☐No
Is the patient able to sit and maintain position? ☐Yes ☐No
Is the patient combative or have any behavior issues? ☐Yes ☐No

Describe Patient's signs of difficulty:
Throat clearing with: ☐Liquid ☐Food ☐Pills/Medication
Coughing with: ☐Liquid ☐Food ☐Pills/Medication
Choking with: ☐Liquid ☐Food ☐Pills/Medication

Patient Name:_____ **HCN:**_____

☐ **Nursing for teaching IV (up to 3 visits)**

Teaching/consultation required for e.g. IV:_____
LTC home has explored all other supports including the home's (or corporate/region) clinical educator, pharmacy, vendor, Nurse Practioner Led Outreach Team and contacted agencies? ☐Yes ☐No
LTC home's clinical educator or DOC/charge nurse(s) would be present for the training? ☐Yes ☐No
LTC home has a plan for the ongoing skills maintenance/training? ☐Yes ☐No
Medical equipment (e.g. pump), supplies and medications are in place, if applicable? ☐Yes ☐No

Please do no send referral until the above are in place

☐ **Wound Consult Assessment (1-2 visits)**

Location of wound(s):_____
Wound measurements (LxWxD):_____
Dressing treatment/frequency:_____
Reason for wound consult nurse assessment:_____

Please do no send referral until the above are in place

Additional Information:

_____ dd/mm/yyyy _____
Signature of LTCH staff completing referral — Date

_____ _____
Print Name/Designation — Number/Extension for Unit

Print Clear