Local Health Integration Networks

Alternative Level of Care, Resource Matching and Referral Business Transformation Initiative (ALC RM&R BTI)

Provincial Referral Standards Reference Guide V5

November, 2014

Ontario
Local Health Integration Network

Contents

Reference Guide Revision History

Date	Version	Revision
October 3rd, 2013	Provincial Referral Standards Reference Guide	Final
January 30th, 2014	Provincial Referral Standards Reference Guide V2	1. Revision History 2. CCAC Definition of "Other Legal Oversight" 3. Embedded Final LTC Form 4. Updated Footer to show V2 5. Updated Table of Contents
March 26, 2014	Provincial Referral Standards Reference Guide V3	1. March Provincial Referral Standards Revisions 2. Rehab/CCC Definition "Relevant Diagnosis for Referral' 3. Rehab/CCC Definition "Weight Bearing Status" 4. References – Thunder Bay Regional Health Sciences.
July 2014	Provincial Referral Standards Reference Guide V4	1. Definition for 'Durable Power of Attorney'added to LTC 2. Corrected Rehab/CCC definition for 'Primary Health Care Provider (e.g. MD, NP)'
November 2014	Provincial Referral Standards Reference Guide V5	1. Included prompting descriptor within Cognition Section (Pg.26) 2. Included prompting descriptor within Social History section (Pg. 28) 3. USDMR request to clarify reference to AlphaFIM® as the trademark itself should include a noun after AlphaFIM© (i.e. Instrument, Assessment, Tool) (Pg. 30) 4. Wording in preface updated to reflect current state

Preface

To assist with both the implementation and ongoing use of developed Provincial Referral Standards, it is important that LHINs and their Health Service Providers (HSPs) are able to understand the rationale for each of the data elements within each of the four in-scope care pathways. Having this information will help LHINs when preparing their education tools and will also support them when engaging in discussions with participating Health Service Provider (HSP) sites during the Initial Implementation. The reference sheets are meant to act as an aid and should be supplemented with any additional LHIN specific supporting materials required for your HSP site training. This reference guide provides basic information on a provincial level and LHINs should view this as a starting point which may require further defining within each of the Provincial Referral Standards to support cluster specific customized fields which have not been addressed within this document.

The content of this reference guide was retrieved from various sources over the last 2 years and includes: Subject Matter Expert (SME) engagement sessions at the Cluster and Provincial level; Provincial Circle Back Webinars, Initial Implementation; and Cluster-based and provincial referral form change logs. The information included in this reference guide has been provided to you based on our knowledge of SME feedback provided and collected at the provincial level. In addition, for some data fields where provincial agreement was not achieved, the project team consulted with specific provincial expert bodies, which include the Rehabilitative Care Alliance, CCAC leadership, and the Senior Care Strategy to provide the right direction. Final feedback from the provincial expert bodies was taken forward to the cluster lead CEOs for approval. All best practice fields are now finalized and included in the provincial referral standards for implementation.

NOTE:

It is the expectation that changes will not be made to the content of this reference guide, with the exception of additions required to support specific Cluster customized fields. If a LHIN or Cluster feel that a definition needs to be addressed, we respectfully ask that the LHIN or Cluster bring forward any recommended changes to the RM&R Provincial Standards Sustainability Office (PSSO) by emailing ALCRMandRBTI@LHINS.ON.CA prior to making any changes.

Appendix A- CCAC Referral Reference Sheet

If Faxed Include Number of Pages (Including Cover): This will ensure the CCAC Care Coordinator receives the full referral.		
Estimated Date of Discharge (EDD): This date helps CCAC to triage referrals		
Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Health Card #:	Health card number (HCN) is required to validate that an individual is entitled to health care services paid by OHIP. (Ministry of Health and Long-Term Care[1]).	
Version Code:	If patient has a version code (not all patients will), this version code is part of the validation process.	
Province Issuing Health Card:	CCAC's can register and assess any individual without an Ontario HCN who has been identified as requiring services in Ontario. Province issuing HCN will alert CCAC that referral is for an out of province patient and this information will be captured in the No Health Card Field in CHRIS. This also gives a heads up to the CCAC that the patient is from out of Province and will require a separate process.	
No Health Card #: ☐	When processing the referral, Care Coordinator will identify in CHRIS the rational for no HCN; this will then allow CCAC to determine payment liability (e.g. Veteran, RCMP, out of province patient).	
No Version Code: ☐	Not all patients will have a version code.	
Surname and Given Name(s):	This is used as a patient identifier	
Home Address, City, Province, Postal Code	This is the address where the patient resides and may be the location where services will be provided and validates the LHIN where the patient resides to ensure the correct CCAC receives the referral.	***Acronym*** **LHIN**-Local Health Integration Network
No Known Address: ☐	Some patient populations will not have a home address (e.g. homeless, prison population). This information is helpful for the CCAC to know upfront.	

Telephone # ; Alternate Telephone #	Primary telephone # for CCAC to contact patient; alternate (e.g. cell phone) if patient cannot be reached at primary number.	

CCAC Referral Reference Sheet Continued

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Address for Treatment (Complete if different than home address); City, Province	Address patient will be residing at when care is being provided by the CCAC (e.g. patient going to daughter's home post discharge). City will identify for the Care Coordinator whether different address is in same or other LHIN.	If the address for treatment is NOT different from Home Address, these fields can be left blank (i.e. not mandatory). The user will still see these fields and will have the option to complete.
Telephone #; Alternate Telephone #; No Alternate Telephone #	Primary telephone # for CCAC to contact patient at address for treatment; alternate (e.g. cell phone) if patient cannot be reached at primary number; may only have a primary telephone #.	
Date of Birth:	Part of the health card validation process; unique patient identifier.	
Gender: ☐ M ☐ F ☐ Other	Patient identifier. May be required for room accommodation (e.g. LTC application); required for LTC wait list.	
Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No Primary Language: ☐ English ☐ French ☐ Other	To ensure CCAC Care Coordinator is able to converse with patient and identify if an interpreter will be required to have a fulsome understanding of assessments and services required to support the patient needs. Information will also be shared with other HSPs so they can prepare to meet the patient needs.	***Acronym*** **HSPs**- Health Service Providers
Primary Alternate Contact Person:	Primary contact person (other than patient). This may be a legal or non-legal contact. Also used as emergency contact if required.	
Relationship: ☐ POA ☐ SDM ☐ Spouse ☐ Other (Check all applicable boxes)	Describes the role of the primary contact as it relates to legal or non-legal decisions of the patient's care. More than one option can be selected at the same time (e.g. Spouse and POA).	***Acronyms and Definitions*** **POA**-Power of Attorney **SDM-**Substitute Decision Maker **Spouse**-Partnership in marriage, civil union, domestic partnership, common-law. **Other**-Daughter, son, or another individual who play a care giver role.

Telephone # ; Alternate Telephone #; No Alternate Telephone #	Primary and alternate telephone #s where the alternate contact may be reached; may only have primary telephone #.	If an Alternate Tel# is provided, the 'No Alternate Tel#' field can be left blank (i.e. not mandatory if Alternate Tel# is provided).

CCAC Referral Reference Sheet Continued

Health Information		
Community Primary Health Care Provider (e.g. MD, NP) None: ☐	Primary Care Provider that follows the patient in the community. Also important information to be captured since the Provincial initiative of Health Links aims to attach complex patients with Primary Care Providers. If the patient does not have a Primary Care Provider CCAC will engage and prepare to procure a provider for the patient via Health Care Connect.	***Acronyms*** **MD-** Medical Doctor **NP**- Nurse Practitioner
Surname; Given Name(s):	Primary Care Provider's last and first name.	
Relevant Diagnosis for Referral: *(Please Include Surgical Procedure(s) and Date(s))*	Diagnosis that prompts the CCAC referral, requiring patient assessment. This will help to provide some context as to the rationale for the referral and trigger patient care needs. (e.g. Insulin Dependent Diabetic) Including any relevant surgical procedure and date will help the CCAC Care Coordinator in triage of referrals for particular care paths (e.g. hips, knees)	

Health Information		
Data Field	**Rationale for Requested Information**	**Other**
Reason for Referral:	The Reason for Referral is used to reflect the functional/medical needs of the client (wound care, IV therapy, needs home care assessment etc.) It is not meant to be a request for a type of service requested such as OT, PT. Once the referral from Acute Care is received, the CCAC will conduct a patient assessment and determine what types of services the patient needs. Some examples below were provided during consultation with the CCAC sector to assist in training the Acute sector in what type of information is expected when completing this section of the form. Examples: • Frail Senior, lives alone, mobility declining and at risk for falls • Palliative client would like to die at home. PPS 30%, Prognosis less than 3 months. • Rapid progression of parkinsonian symptoms and at risk of falls. Has slurred speech and occasional swallowing difficulty. • Short-term memory loss secondary to stroke. Needs reminders to take medications and perform ADLs	
Allergies: ☐ No Known Allergies ☐ Yes---If Yes, List	The lack of Allergy information could have devastating impacts on patient safety and care and therefore it is important that the sending facility documents all relevant allergies (Drug, Food, Latex etc.) upfront in the referral process to alert the CCAC. It is expected that when CCACs receive the referral, they will undertake a validation exercise to confirm the Allergies, as Medical Orders may not be attached with all referrals and there might be additional information that comes to light when assessing the patient care needs. This ensures that Allergies are assessed from both the Acute Care and CCAC perspective for improved patient safety and quality of care.	

Health Information		
Data Field	**Rationale for Requested Information**	**Other**
Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ C. diff ☐ ESBL ☐ TB ☐ Other	To alert the CCAC if the patient requires any Infection Control practices and/or accommodations when providing care (e.g. private room, personal protective equipment).	***Definitions:*** **None-** Patient is negative for the following pathogens and does not require Infection Control practices; if one of the boxes is checked off patient is considered positive. **MRSA-**Methicillin- resistant Staphylococcus aureus **VRE-** Vancomycin-resistant Enterococcus **C. diff-**Clostridium difficile **ESBL-** Extended-Spectrum Beta-Lactamas-Producing Bacteria **TB-**Tuberculosis **Other-**patient may be isolated or may require Infection Control practices related to diarrhea, or symptoms of unknown etiology. (PIDAC, 2013[2])

Health Information		
Data Field	**Rationale for Requested Information**	**Other**
Medical Orders: ☐ No ☐ Attached	When processing the referral it will be identified if the medical orders are attached or not. Medical orders are only required in the following instances as provided in the standard definition of Medical Orders according to the ***College of Nurses of Ontario (2011)3***: A Registered Nurse must have a written or verbal order to perform the following: 1. Performing a prescribed procedure below the dermis or mucous membrane. 2. Administering substances by injection or inhalation. 3. Putting an instrument, hand, or finger: beyond the external ear canal; beyond the point in the nasal passage where they normally narrow; beyond the larynx; beyond the opening of the urethra; beyond the labia majora; beyond the anal verge or into an artificial opening in the body.	

Health Information		
Data Field	**Rationale for Requested Information**	**Other**
Referring Facility/Unit: Facility Contact Number:	Referring facility and/or unit that are sending the referral request. This is needed in the event further information is required on the patient. CHRIS data fields track where referrals originate in the hospital. Facility telephone #	
Completed By; Title, Date; Contact #	The person completing the referral must be identified in the event that the CCAC requires follow-up information related to the patient and referral.	***Definition*** **Title**- Person filling in the form to identify their discipline or role (e.g. RN, Social Work, Unit Clerk)

Appendix B- LTC Referral Reference Sheet

If Faxed Include Number of Pages (Including Cover): This will ensure the Long Care Home facility receives the full referral including any attachments		
Patient Details and Demographics		
Data Field	**Rationale for Requesting Information**	**Other**
Health Card #:	Health card number (HCN) is required to validate that an individual is entitled to health care services paid by OHIP. (Ministry of Health and Long-Term Care[1]).	
Version Code:	If patient has a version code (not all patients will), this version code is part of the validation process.	
Province Issuing Health Card:	CCAC's can register and assess any individual without an Ontario HCN who has been identified as requiring services in Ontario. Province issuing HCN will alert CCAC that referral is for an out of province patient and this information will be captured in the No Health Card Field in CHRIS. This also gives a heads up to the CCAC that the patient is from out of Province and will require a separate process.	
No Health Card #: ☐	When processing the referral, CCAC Case Manager will identify in CHRIS the rational for no HCN; this will then allow CCAC to determine payment liability (e.g. Veteran, RCMP, out of province patient etc.).	
No Version Code: ☐	Not all patients will have a version code.	
Surname and Given Name(s):	This is used as a patient identifier.	
Home Address, City, Province, Postal Code	This is the address where the patient currently resides and validates the LHIN where the patient resides to ensure the correct CCAC receives the referral.	***Acronym*** **LHIN-** Local Health Integration Network
No Known Address: ☐	Some patient populations will not have a home address (e.g. homeless, prison population). This information is helpful for the CCACs to know upfront.	

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Telephone # ; Alternate Telephone #; No Alternate Telephone #☐	Primary telephone # for CCAC/or LTCH to contact patient at address for treatment; alternate (e.g. cell phone) if patient cannot be reached at primary number; may only have a primary telephone #.	
Current Location and Address:	This identified information is related to where the patient is currently residing. It will by default be the Hospital Location and Address, unless the patient has been discharged home and waiting for LTC follow up.	
Ethno-Cultural Preferences:	Necessary for waitlist as some homes are formally designated as ethno-cultural specific. Some homes have informal unit designations that can be considered.	
Application Type: ☐ Long Stay ☐ Short Stay-Respite ☐Short Stay- Interim Care ☐ Short Stay-Convalescent Care	This identifies for the CCAC the specific patient care need requirements and helps them in directing the application to the appropriate LTCH as requested.	
Is the Patient Capable to Make LTC Admission Decisions: ☐Yes ☐ No	Indication to the LTCH of capacity and expectation of Substitute Decision Maker, Power of Attorney or other legal oversight.	
Primary Health Care Provider (e.g. MD or NP): ☐ None	The Ministry of Health and Long-Term Care mandates that all LTCHs have a Medical Director and facility physician. The patient's Primary Health Care Provider is required to transfer patient care from one care provider to another.	***Acronyms*** **MD**- Medical Doctor **NP**- Nurse Practitioner
Surname; Given Name(s):	Primary Care Provider's last and first name.	

Patient Contacts		
Data Field	**Rationale for Requested Information**	**Other**
Primary Alternate Contact Person:	Primary contact person (other than patient). This may be a legal or non-legal contact. Also used as emergency contact if required.	
Secondary Alternate Contact Person:	Secondary contact person in the event the primary cannot be reached.	
None Provided: ☐	'None Provided' field ensures the field was addressed and not missed. Not all patients will have 2 contacts.	
Relationship to Patient: ☐ Spouse ☐ Other		
Primary and Secondary Alternate Contacts Address; City; Postal Code; Tel# (Home); Tel# (Work)	Contact information in which the CCAC or LTCH can reach the primary and/or secondary contact person(s).	
Emergency Contact: ☐Yes ☐ No	Clearly identifies if the primary/alternate contact is also deemed as the emergency contact.	
Responsibility: (Please Check All Applicable Boxes) ☐ Substitute Decision Maker; ☐ Other legal oversight; ☐ Durable Power of Attorney (Personal Care)- (Jointly/Jointly and Severally) ☐ Durable Power of Attorney (Property)- (Jointly/Jointly and Severally) ☐ Public Guardian Trustee	Information about legal and non-legal contacts for the LTCH when communication in the event that the patient is deemed not capable of making property or personal care decisions. More than one option can be selected at the same time (e.g. Spouse, POA).	"**Other legal oversight**" falls under those individuals who are able to give consent on behalf of an incapable person (e.g. this would be a person appointed by the courts- court appointed guardian or someone appointed by the consent and capacity board). **"Durable Power of Attorney (Personal Care) – (Jointly/Jointly and Severally)"** • "attorney for personal care" means an attorney under a power of attorney for personal care made in accordance with the Substitute Decisions Act, 1992;

		("procureur au soin de la personne"). For further information please refer to the Ontario Consent & Capacity Legislation or http://www.millerthomson.com/assets/files/health_portal/571165_1_Understanding%20Legal%20Documents%20for%20Guardianship,%20Power%20of%20.PDF **Durable Power of Attorney (Property) – (Jointly/Jointly and Severally)** • "attorney for property" means an attorney under a continuing power of attorney for property made in accordance with the Substitute Decisions Act, 1992; ("procureur aux biens". For further information please refer to the Ontario Consent & Capacity Legislation or http://www.millerthomson.com/assets/files/health_portal/571165_1_Understanding%20Legal%20Documents%20for%20Guardianship,%20Power%20of%20.PDF

Additional Information		
Data Field	**Rationale for Requesting Information**	**Other**
Please Include with this Application the Following ☐ Health Assessment Form ☐ RAI-HC Assessment ☐ Smoking Assessment (If patient currently has or has had behaviour issues in the last 12 months) ☐ Behavioural Assessment. (If patient currently has or has had behaviour issues in the last 12 months). ☐ SDM/POA/PGT (as needed) ☐ Hospital Convalescent Care Transfer Form (for convalescent Applications) ☐ All relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology, any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)	The Provincial Sponsor engaged with the CCAC LTC Placement managers table and Provincial Client Services table to validate that these attachments are standardized and in use across all 14 LHINs. These attachments represent the standard list of agreed upon information that needs to be sent with the LTC cover sheet. The LTC cover sheet and all the listed attachments represent a standard and complete provincial LTC application package. ***Please note that the HAF and RAI-HC are Ministry legislated and standardized forms.***	***Other Information*** The standard LTC Application package, cover sheet and attachments has been appended to this guide for your reference.
Completed by; Title; Date; Contact Number	The person completing the referral must be identified in the event that the LTCH requires follow up-information related to the patient and referral.	
If Faxed Include Number or Pages (Including Cover)	This will ensure that the LTC referral /application package is received in full and that no information is lost during transmission.	

Appendix C- Rehab & CCC Referral Reference Sheet

If Faxed Include Number of Pages (Including Cover): This will ensure the Rehab or CCC facility receives the full referral including any attachments		
Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY Estimated date of when the patient will be ready for transition into a Rehab/CCC program		
Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Health Card #:	Health card number is required to validate that an individual is entitled to health care services paid by OHIP. (Ministry of Health and Long-Term Care[1])	
Version Code:	If patient has a version code (not all patients will), this version code is part of the validation process.	
Province Issuing Health Card:	In the event that patient is from out of province, there will be no confusion as to the type of health card and corresponding number.	
No Health Card #: ☐	This is required to capture patients who may not have an Ontario Health Card Number, but are entitled to services paid by OHIP (e.g. Veterans, RCMP); or patients being admitted from out of province or country.	
No Version Code: ☐	Not all patients will have a version code.	
Surname and Given Name(s):	This is used as a patient identifier.	
Home Address, City, Province, Postal Code, Country	This is the address of the patient's home.	***Other Information*** Country is included as Rehab facilities admit out of country patients.
No Known Address: ☐	Some patient populations will not have a home address (e.g. homeless, prison population). This information is helpful for the CCACs to know upfront.	
Telephone # ; Alternate Telephone #; No Alternate Telephone #☐	Primary telephone # for Rehab/CCC facility to contact patient; alternate (e.g. cell phone) if patient cannot be reached at primary number; patient may only have a primary telephone #.	
Current Place of Residence (Complete If Different From Current Address)	This will alert the facility to the address where the patient is currently residing (e.g. temporary residence such as relative's home).	
Date of Birth:	Part of the health card validation process; unique patient identifier.	
Gender: ☐ M ☐ F ☐ Other	Patient identifier. May be required for room accommodation.	

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Marital Status:		
Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No Primary Language: ☐ English ☐ French ☐ Other	To ensure the Rehab/CCC facility is able to converse with patient and identify if an interpreter will be required to have a fulsome understanding of assessments and services required to support the patient needs. Information will also be shared with other HSPs so that they can prepare to meet the patient needs.	***Acronym*** **HSPs**- Health Service Providers
Primary and Secondary Alternate Contact Person	Primary contact person (other than patient) and/or secondary contact. This may be a legal or non-legal contact. Also used as emergency contact if required.	
Relationship to Patient: ☐ POA ☐ SDM ☐ Spouse ☐ Other	Describes the role of the primary and secondary contacts as it relates to legal or non-legal decisions of the patient's care. More than one option can be selected at the same time, i.e. "Spouse" and "POA".	***Acronyms and Definitions*** **POA**-Power of Attorney **SDM-**Substitute Decision Maker **Spouse**-Partnership in marriage, civil union, domestic partnership, common-law. **Other**-Daughter, son, or another individual who plays a social role
Telephone # ; Alternate Telephone #;	Primary and alternate telephone # where contacts can be reached.	
Insurance: N/A: ☐	Insurance number and carrier name. Private insurance required for out of province and out of country patients. Insurance is also required in addition to OHIP for Ontario patients requesting preferred accommodations that are not covered by OHIP. In some situations Insurance is not required thus the N/A field.	***Specific to CCC*** Co-payment is specific to this pathway. Prior to the CCC application being sent, it is important that a discussion has taken place with the patient or SDM/POA/family to ensure they are aware of their financial responsibilities. (MOHLTC [4])

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Program Requested:	Type of Rehab and CCC program the sender is requesting for the patient.	***Other Information*** Subject matter experts have suggested that a list of programs available and their description would be helpful for completing the referral to ensure patient is assigned to most appropriate program. This information need is currently being addressed by the Rehabilitative Care Alliance as part of their work plan for FY 2013/14. In the interim, if a cluster has an agreed upon list of Rehab and CCC programs/services, they are encouraged to use this list for the initial implementation. Once the Rehabilitative Alliance provides the province with the standard list of program and services to be used, the Provincial Referral Standards will be refreshed to include this information.
Current Location Name:	Location of the Hospital where the patient currently is residing. To identify where the patient is located and can be contacted.	
Current Location Address; City; Province, Postal Code	Contact information for the Hospital where the patient is currently residing. To identify where the patient is located and can be contacted.	
Current Location Contact Number:	Contact number for the Hospital unit where the patient is currently residing, in the event that the receiving facility requires further information related to the patient.	
Bed Offer Contact (Name and Number):	Contact number for unit staff at the sending facility for notification of bed offer.	

Medical Information		
Data Field	**Rationale for Requested Information**	**Other**
Primary Health Care Provider (e.g. MD, NP) None: ☐	The referring Physician/Designate i.e. the Attending Physician in the acute care hospital that is making the referral	***Acronyms*** **MD**- Medical Doctor
		NP- Nurse Practitioner
Surname; Given Name(s)	Primary Care Provider's last and first name.	
Reason for Referral:	Example; Patient to return to pre-morbid level of function and/or current multi-system needs.	
Allergies: ☐ No Known Allergies ☐ Yes---If Yes, List	The lack of Allergy information could have devastating impacts on patient safety and care and therefore it is important that the sending facility documents all relevant allergies (Drug, Food, Latex etc.) upfront in the referral process to alert the receiving facility.	
Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ C. diff ☐ ESBL ☐ TB ☐ Other(Specify)	To alert the receiving facility if the patient requires any Infection Control practices and/or accommodations when providing care (e.g. private room, personal protective equipment).	***Acronyms and Definitions*** **None-** Patient is negative for the following pathogens and does not require Infection Control practices; if one of the boxes is checked off, patient is considered positive.
		MRSA-Methicillin- resistant Staphylococcus aureus
		VRE- Vancomycin-resistant Enterococcus
		C. diff-Clostridium difficile
		ESBL- Extended-Spectrum Beta-Lactamas-Producing Bacteria
		TB-Tuberculosis
		Other-patient may be isolated or may require Infection Control practices related to diarrhea, or symptoms of unknown etiology. (PIDAC, 2013[2])

Medical Information		
Data Field	**Rationale for Information Requested**	**Other**
Admission Date: Date of Injury: Surgery Date:	Provides a snapshot of the patient's journey by providing a timeline form injury to post-op to appropriate program.	
Rehab Specific Patient Goals: ***CCC Specific*** Patient Goals:	This describes for the receiving facility the goals for care and successful discharge. Goals should be specific, measurable, achievable, realistic and timely.(e.g. Mrs. Smith will feed herself independently with set up in 1 month; Mr. Jones will walk indoors independently without a gait aid in 3 months).	***Other Information*** Important to note patient goals for both Rehab and CCC depending on the program the patient is being referred to.
Nature/Type of Injury/Event:	Description of injury (e.g. stroke, spinal cord injury, medically complex).	
Primary Diagnosis:	Diagnosis on admission; the condition that motivated the initial hospitalization.	
History of Presenting Illness/Course in Hospital:	Clinical course of patient during hospitalization (e.g. presenting symptoms, infections, surgical complications).	
Current Active Medical Issues/Medical Services following Patient:	Current active medical issues that are being followed by other medical services (e.g. Nephrology, Cardiology).	
Past Medical History:	Historical perspective and account of the patient's past medical needs or crisis. Includes describing any past major illnesses, surgeries, and patient's health status prior to the presenting problem (e.g. current or ongoing medical conditions such as diabetes).	
Height and Weight:	Required to determine bariatric needs. This information is helpful in identifying if the receiving facility can accommodate the patient.	
Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days Location:	To determine if the facility can accommodate/support the treatment on site. To determine if the frequency of the treatments and travel time will not impact the patients ability to participate in the program. Transportation requirements would need to be assessed.	***Examples*** **Frequency:** e.g. Daily, 3 X weekly **Days**: e.g. M-W-F **Location**: Where treatment will take place (e.g. off-site, on-site)

Medical Information		
Data Field	**Rationale for Requested Information**	**Other**
Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No Frequency: Duration: Location	Refer to Dialysis	***Examples and Definition*** **Frequency**; How often the patient receives treatments (e.g. daily, weekly, monthly) **Duration:** Length of time required to receive the treatment.
Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No Frequency: Duration: Location:	Refer to Dialysis	Refer to Chemotherapy
Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ NO ☐ Details	Refer to Dialysis	
CCC Specific Medical Prognosis ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative ☐ Unknown Palliative Performance Scale	Prediction of the probable outcome of the course of the disease and/or patient's health. It was identified that this information is provided by a physician. However, it is important to note that although a physician provides this information, they do not necessarily have to complete the actual referral form to do so. The physician can provide this information through any document, and the person filling out the form (NP, RN or other) can then just transcribe the physician noted information into the referral form.	
Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other	Allied Health Services consulted in the care of the patient during the course of their hospitalization.	***Acronyms*** **PT**- Physiotherapy **OT**-Occupational Therapy **SW**- Social Work
Pending Investigations: ☐ Yes ☐ No Details	Scheduled or pending investigations not completed (e.g. MRI) This information may be pertinent in determining patient acceptance and type of program required.	
Frequency of Lab Tests: ☐ Unknown ☐ None	Transportation requirements may be needed if lab tests cannot be accommodated on site. Also to determine impact on patient's participation in the program and ability to participate.	

<table>
<tr><th colspan="3">Respiratory Care Requirements</th></tr>
<tr><th>Data Field</th><th>Rationale for Requested Information</th><th>Other</th></tr>
<tr><td colspan="2">Does the Patient Have Respiratory Care Requirements?

☐ Yes ☐ No --- If No Skip to Next Section</td><td rowspan="6">This question is intended to prompt the sender to include any respiratory care requirements to ensure the receiving facility has the equipment and staff trained to support the patient. Patients referred to CCC programs often require specialized respiratory care and equipment to support their health.</td><td rowspan="2"></td></tr>
<tr><td>Supplemental Oxygen:

☐ Yes ☐ No</td><td>Ventilator:

☐ Yes ☐ No</td></tr>
<tr><td>Breath Stacking:

☐ Yes ☐ No</td><td>Insufflation/Exsufflation

☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless</td><td rowspan="3">Example

Frequency: This describes how often the patient requires suctioning (e.g. hourly, or as required)</td></tr>
<tr><td colspan="2">Suctioning: ☐ Yes ☐ No Frequency:</td></tr>
<tr><td colspan="2">C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No

Patient Owned: ☐ Yes ☐ No</td><td></td><td></td></tr>
<tr><td colspan="2">Additional Comments:</td><td>Provide any information that has not been shared but is critical to ensure a safe transition to Rehab or CCC.</td><td></td></tr>
</table>

IV Therapy		
Data Field	**Rationale for Requested Information**	**Other**
IV in Use: ☐ Yes ☐ No--- If No skip to Next Section	To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	***Acronym*** **PICC**- Peripherally Inserted Central Catheter
IV Therapy: ☐ Yes ☐ No		
Central Line: ☐ Yes ☐ No		
PICC Line: ☐ Yes ☐ No		
Swallowing and Nutrition		
Swallowing Deficit: ☐ Yes ☐No	To identify that patient may have special needs related to the swallowing deficit.	
Swallowing Assessment Completed: ☐ Yes ☐ No	If yes, information in report will be of benefit to the receiving facility and will outline plan of care; if No facility may not have the ability to complete assessment on site and may require completion prior to accepting the patient. It is our understanding that any information related to the swallowing assessment is part of the speech pathology reports under (other consultative reports section) of the referral form.	
Type of Swallowing Assessment and Details:	Information that will help determine best program and care for patient.	
TPN: ☐ Yes (If Yes, Include Prescription with Referral) ☐ No	To ensure the receiving facility has the equipment and staff trained to support the patient's needs. To ensure Pharmacy has the ability to prepare or obtain the solution required.	***Acronym*** **TPN**-Total Parenteral Nutrition
Enteral Feeding: ☐ Yes ☐ No	To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	

Skin Condition		
Data Field	**Rationale for Requesting Information**	**Other**
Surgical Wounds and/or Other Wounds Ulcers: ☐ Yes ☐ No--- If No, Skip to next Section	Required to alert receiving facility of required wound care support. To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	
Location: Stage:	To ensure the receiving facility has the equipment (VAC or Negative Pressure Wound Therapy) and staff trained to support the patient's needs. Facility may not be able to support wound management care plan. Frequency and time to complete dressing is required to review impact on the patient's time to participate in the program.	***Definition and Acronym*** **Location**: This is the location of the wound or ulcer on the patient body.
Dressing Type: Frequency: (e.g. Negative Pressure Wound Therapy or VAC)		**VAC**-Vacuum Dressing **Frequency**: How often the dressing is changed (e.g. daily, twice daily)
Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes		
** If additional wounds exist, add supplementary information on a separate sheet of paper.*	Supplementary information can be part of the attachments included with the referral.	
Continence		
Is Patient Continent: ☐ Yes ☐ No--- If Yes, Skip to Next Section	Required for patient care planning.	
Bladder Continent: ☐Yes ☐ No If No: ☐ Occasional Incontinence ☐Incontinent		
Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐Incontinent		

Pain Care Requirements		
Data Field	**Rationale for Information**	**Other**
Does the Patient Have a Pain Management Strategy: ☐ Yes ☐ No ---If No, Skip to Next Section	Patient's ability to participate successfully in a program is dependent upon controlled pain. Receiving facility may request pain management plan prior to accepting patient.	
Controlled With Oral Analgesics: ☐ Yes ☐ No	This information will provide the facility with the type of care needs required to support the patient.	
Medication Pump: ☐ Yes ☐ No		
Epidural: ☐ Yes ☐ No		
Has a Pain Plan of Care Been Started: ☐ Yes ☐ No	Patient's ability to participate successfully in a program is dependent upon controlled pain.	
Communication		
Does the Patient Have a Communication Impairment: ☐ Yes ☐ No ---If No, Skip to Next Section	This information will provide the facility with the type of care needs required to support the patient.	
Communication Impairment Description:	Describe the type of communication impairment (e.g. Aphasia, articulation problems).	
Cognition		
Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess---If No, or Unable to Assess, Skip to Next Section	If the patient's ability to learn and retain information is impaired, include information on whether issues can be mitigated through caregiver support or other environmental cues/considerations. Required to understand if patient's cognition will impair ability to participate in the program. The type of cognitive impairment will determine the appropriate Rehab or CCC program Delirium can be attributed to several things (e.g. Chronic condition; infection, medications, surgery and drug/alcohol abuse). This will be important information for the receiving facility when determining the appropriate program for the patient.	
Details on Cognitive Deficits:		
Has the Patient Shown the Ability to Learn and Retain Information: ☐ Yes ☐ No--- If No, Details:		
Delirium: ☐ Yes ☐ No--- If Yes, Cause/ Details:		

History of Diagnosed Dementia: ☐ Yes ☐ No	People with dementia require skilled interventions in a controlled environment. The receiving facility will want to ensure they can support this type of patient safely.	

Behaviour		
Data Field	**Rationale for Information**	**Other**
Are There Behavioural Issues: ☐ Yes ☐ No--- If No, Skip to Next Section	People with challenging behaviours require skilled interventions in a controlled environment. The receiving facility will want to ensure they can support the patient safely. This includes the facility having the type of environment that the patient requires (e.g. secure unit).	
Does the Patient Have a Behaviour Management Strategy: ☐ Yes ☐ No		
Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering ☐ Sundowning ☐ Exit-Seeking ☐ Resisting Care ☐ Other ☐ Restraints---If Yes, Type/Frequency Details:		
Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one.		

Social History		
Data Field	**Rationale for Requesting Information**	**Other**
Discharge Destination: ☐ Multi-Storey ☐ Bungalow ☐ Apartment ☐ LTC ☐ Retirement Home (Name)	Discharge destination will help to direct patient's Rehab/CCC goals and supporting care plan. If patient does not have a discharge destination in place, work will be required to find a suitable discharge destination; receiving facility may request a repatriation agreement with the sending facility in the event a discharge destination is not found.	
Accommodation Barriers: ☐ Unknown	Accommodation barriers that must be dealt with prior to the patient returning home. This becomes part to the patient care plan (e.g. stairs).	
Smoking: ☐ Yes ☐ No ☐ Details Alcohol and/or Drug Use: ☐ Yes ☐ No ☐ Details	Smoking assessment and care plan may be required as the receiving facility may not be able to support the patient's smoking needs; or drug/alcohol withdrawal needs (e.g. Methadone).	
Previous Community Supports: ☐ Yes ☐ No ☐ Details	Helpful for determining care planning needs.	
Discharge Planning Post Hospitalization Addressed: ☐Yes☐ No ☐ Details Discharge Plan Discussed with Patient/SDM: ☐ Yes ☐ No	To ensure the patient or SDM clearly understands his/her discharge destination and targeted length of stay. Include information on the availability of family support during admission.	***Acronym*** **SDM**-Substitute Decision Maker

Current Functional Status		
Data Field	**Rationale for Requesting Information**	**Other**
Sitting Tolerance: ☐ More Than 2 Hours Daily ☐ 1-2 Hours Daily ☐ Less Than 1 Hour Daily ☐ Has not Been Up	Patient functional status information will help direct patient to most appropriate program which will enhance patient's independence. Physical tolerance will help the receiver understand the patient's functional ability to participate and direct to the appropriate program (e.g. high tolerance program, low tolerance program). **Definitions for Weight Bearing Status** Full= The patient may place their full body weight on the affected leg when standing or walking As Tolerated= When walking or standing the patient evenly distributes their weight through their legs and may place only as much weight as feels comfortable on the affected leg. Pain will be the guide for the patient as they feel pain they should place less weight on the affected leg. Partial= When the patient stands or walks they may place a percentage of their body weight on the affected leg – this will be at the direction of their physician. Toe Touch= When the patient stands or walks they may touch the floor only for balance and do not place actual full weight on their affected leg; almost all of their weight is taken through the arms with the aid of a walker or crutches. Non= The patient cannot place any weight on their affected leg. Do not touch the floor with the affected leg. While standing or walking they must hold their affected leg off the floor. Reference: Thunder Bay Regional Health Sciences, Total Joint Clinical Pathway Team 2008. Retrieved from http://www.tbrhsc.net/site_wide_references/surgical_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20(Restricted%20Weight%20Bearing).pdf	
Transfers: ☐ Independent ☐ Supervision ☐ Assist X1 ☐ Assist X2 ☐ Mechanical Lift		
Ambulation: ☐ Independent ☐ Supervision ☐ Assist X1 ☐ Assist X2 ☐ Unable Number of Meters:		
Weight Bearing Status: ☐ Full ☐ As Tolerated ☐ Partial ☐ Toe Touch ☐ Non		
Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist X1 ☐ Assist X2		

<table>
<tr><th colspan="8">Activities of Daily Living</th></tr>
<tr><th colspan="7">Data Field</th><th>Rationale for Requesting Information</th><th>Other</th></tr>
<tr><td colspan="7">Level of Function Prior to Hospital Admission (ADL & IADL)

Current Status Table-Complete the Table Below</td><td rowspan="2">To have an understanding of the patients premorbid level of functioning and a baseline to gauge the patient's progress.</td><td>Acronyms

ADL-Activities of Daily Living</td></tr>
<tr><td colspan="7"></td><td>IADL-Instrumental Activities of Daily Living</td></tr>
<tr><td>Activity</td><td>Independent</td><td>Cueing/ Set/Up or Supervision</td><td>Min. Assist</td><td>Mod. Assist</td><td>Max Assist</td><td>Total Care</td><td rowspan="8">To understand patients current functional status and ability to perform activities of daily living independently.

Other Information
Currently there are no standardized assessment tools for the Rehab and CCC programs. There are no common definitions used across the province that define:
• Independent; Cueing/Setup or Supervision; Minimum Assist; Moderate Assist; Maximum Assist; Total Care.</td><td rowspan="8">Across the province sites are using either the RAI HC-ADL Self-Performance[6] ; the AlphaFIM®[7]- levels of function description and ratings or other Health Service Provider assessment tools or criteria for completing the ADL section. For the Initial Implementation the Provincial Delivery and Project Sponsor will collect feedback on the use of existing resources leveraged by the participating sites to complete the ADL section. In addition we will be adding specific questions in our Rehab and CCC evaluation surveys to help with the assessment of the ADL section. For your reference Appendix D and E provides the definitions from the RAI HC and the AlphaFIM®instrument.</td></tr>
<tr><td>Eating</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Grooming</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dressing</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dressing</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Toileting</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Bathing</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><th colspan="5">Special Equipment Needs</th></tr>
<tr><th colspan="4">Data Field</th><th>Rationale for Requesting Information</th><th>Other</th></tr>
<tr><td colspan="4">Special Equipment Required: ☐ Yes ☐ No--- If No, Skip to next Section</td><td rowspan="5">To ensure the receiving facility has the equipment and staff trained to support the patient's needs.</td><td rowspan="5"></td></tr>
<tr><td colspan="4">☐ Halo ☐ Orthosis ☐ Bariatric ☐ Other</td></tr>
<tr><td colspan="4">Pleuracentesis: ☐ Yes ☐ No
Paracenteisis : ☐ Yes ☐ No</td></tr>
<tr><td colspan="4">Need for Special Mattress: Yes/No</td></tr>
<tr><td colspan="4">Negative Pressure Wound Therapy: Yes/No</td></tr>
<tr><th colspan="5">Rehab Specific
AlphaFIM® Instrument</th></tr>
<tr><td colspan="4">AlphaFIM® Data Available: ☐ Yes ☐ No--- If No, Skip to Next Section</td><td rowspan="8">AlphaFIM® provides a consistent method of assessing patient disability and functional status in the acute care setting. The Alpha-FIM® instrument helps clinicians to obtain expected FIM® ratings, evaluate expected discharge status, and project expected minutes of care. These ratings can then be used to assign a probable discharge disposition from the acute care setting and can be converted into expected minutes of patient care, which help staff and family members understand the patient's resource needs for performing activities of daily living (Uniform Data System for Medical Rehabilitation[5]).

AlphaFIM® results provided with the Rehab and CCC Provincial Referral Standards will be provided by those health service providers who are trained and licenced to use this instrument.</td><td rowspan="8">Trademark/Copyright notice added at bottom of last page of Rehab/CCC referral as requested by UDSMR :

"AlphaFIM and FIM are trademarks of Uniform Data System for Medical Rehabilitation (UDSMR), a division of UB Foundation Activities, Inc. All Rights Reserved. The AlphaFIM items contained herein are the property of UDSMR and are reprinted with permission."</td></tr>
<tr><td colspan="4">Has the Patient Been Observed Walking 150 Feet or More:
☐ Yes ☐ No</td></tr>
<tr><td rowspan="2">If Yes- Raw Ratings(rate levels 1-7):</td><td>Transfers: Bed, Chair</td><td>Expression</td><td>Transfers: Toilet</td></tr>
<tr><td>Bowel Management</td><td>Locomotion: Walk</td><td>Memory</td></tr>
<tr><td rowspan="2">If No- Raw Ratings(rate levels 1-7):</td><td>Eating</td><td>Expression</td><td>Transfers: Toilet</td></tr>
<tr><td>Bowel Management</td><td>Grooming</td><td>Memory</td></tr>
<tr><td rowspan="2">Projected:</td><td>FIM® projected Raw Motor(13)</td><td>FIM® projected Cognitive (5)</td><td></td></tr>
<tr><td>Help Needed</td><td></td><td></td></tr>
</table>

Attachments		
Data Field	**Rationale for Requesting Information**	**Other**
Details on other relevant information that would assist with this referral:	Any pertinent information specific to the patient that might not have been captured in the referral but will help the receiver with their decision making process and patient care planning.	
Please Include with this Referral: ☐ Admission History and Physical ☐ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician) ☐ All Relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US, etc.) ☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology, and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)	These attachments were deemed necessary by Subject Matter Experts as required information to make an accept decision into the Rehab or CCC program.	***Acronyms*** **PT**-Physiotherapy **OT**- Occupational Therapy **SLP-** Speech Language and Pathology **SW**- Social Work **US-**Ultra Sound
Completed by; Title; Date; Contact Number; Direct Unit Phone Number.	The person completing the referral must be identified in the event that the receiving facility requires follow-up information related to the patient and referral. Contact # and direct unit phone provides the facility with specific line to call.	
If Faxed Include Number or Pages (Including Cover)	This will ensure that the Rehab or CCC referral is received in full and that no information is missing.	

Appendix D- RAI HC

The following has been retrieved from Section H: Physical Functioning section ADL Self-Performance of the Hospital MDS-HC Canadian Version October 2002.

Independent: No help, setup, or oversight-OR-Help, setup, oversight provided only 1 or 2 times (with any task or subtask).
Setup Help Only: Article or device provided within reach of patient 3 or more times.
Supervision: Oversight, encouragement or cueing provided 3 or more times during last 3-days-OR- Supervision (1or more times) plus physical assistance provided only 1or 2 times (for a total of 3 or more episodes of help or supervision).
Limited Assistance: Patient highly involved in activity; received physical help in guided manoeuvring of limbs or other non-weight bearing assistance 3 or more times- OR- Combination of non-weight bearing help with more help provided only 1or 2 times during the period (for a total of 3 or more episodes of physical help).
Extensive Assistance: Patient performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: • Weight-bearing support-OR- • Full performance by another during part (but not all) of last 3 days.
Maximal Assistance: Patient involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight-bearing help or full performance of certain subtasks 3 or more times.
Total Dependence: Full performance of activity by another.
Activity Did not Occur: (regardless of ability)

Appendix F- Long Term Care Referral Package

1. Provincial Referral Standards-LTC	 FINAL LTC Provincial Referral Standards Oc
2. Health Assessment Form	 MOH 4768-69 Health Assessment - Dec 20:
3. RAI-HC Assessment Tool	 Hospital%20RAI-HC %20Assessment%20
4. Smoking Assessment (If patient currently has or has had behaviours in the last 12 months)	 Smoking Assessment Tool PS-461 - Septem
5. Behavioural Assessment (If patient currently has or has had behaviours in the last 12 months)	 Behavioural Assessment PS-455.p
6. Hospital Convalescent Care Transfer Form (For Convalescent Applications)	 Transfer Form Convalescent Care - (

References

1. Ministry of Health of Health and Long-Term Care (MOHLTC). (2012-12-06). Ministry Programs Ontario Health Insurance Plan (OHIP). Retrieved from http://www.health.gov.on.ca/en/public/programs/ohip/

2. Provincial Infectious Diseases Advisory Committee (PIDAC). (2013). *Annex A*. Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs) in all Health Care Settings. Retrieved from http://www.publichealthontario.ca/en/eRepository/PIDAC-IPC_Annex_A_Screening_Testing_Surveillance_AROs_2013.pdf

3. College of Nurses of Ontario (CNO). (2011). *Fact Sheet*. Legislation and Regulation: An Introduction to the Nursing Act, 1991. Retrieved from http://www.cno.org/Global/docs/prac/41064_fsNursingact.pdf

4. MOHLTC (2010). *Publications.* Complex Continuing Care Co-payment 2010. Retrieved from http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx

5. Uniform Data System for Medical Rehabilitation (2013). About the Alpha-FIM® System. Retrieved from http://www.udsmr.org/WebModules/Alpha/Alp_About.aspx

6. Hospital MDS-HC Canadian Version (2002).

7. Uniform Data System for Medical Rehabilitation (2009). *The AlphaFIM® Instrument Guide Version 4.01.*

8. Thunder Bay Regional Health Sciences Centre (2008). Total Hip Replacement Exercise Booklet – *Restricted Weight Bearing).* Retrieved from http://www.tbrhsc.net/site_wide_references/surgical_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20(Restricted%20Weight%20Bearing).pdf