

Discharge Referral Form



HRRH, NYGH, SJRH MH, MSH, SM, SRHC
 Fax: 1-888-825-9622 Fax: 905-713-1841
 Tel: 647-404-1411 or 1-877-676-0666
 Tel: 1-866-291-1503

HOSPITAL ADDRESSOGRAPH

Please call before faxing this referral

I. CONSENT			
Referral discussed with client? <input type="checkbox"/> YES <input type="checkbox"/> NO		Verbal consent given to collect, use and disclose information for transmission of referral? <input type="checkbox"/> YES <input type="checkbox"/> NO – <i>DO NOT PROCEED WITH REFERRAL</i>	
Verbal consent given to discuss referral with substitute decision maker? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ED			
Follow Up to Referral Required? <input type="checkbox"/> YES <input type="checkbox"/> NO		Current CCAC Client? <input type="checkbox"/> YES <input type="checkbox"/> NO	CCAC CONTACTED? <input type="checkbox"/> YES <input type="checkbox"/> NO
III. CLIENT INFORMATION			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Other			
English Spoken? : <input type="checkbox"/> YES <input type="checkbox"/> NO Client's preferred Language: _____ Other languages: _____			
IV. GENERAL MEDICAL CONDITION CHECK LIST			
MOBILITY: <input type="checkbox"/> Independent <input type="checkbox"/> Unable to climb stairs <input type="checkbox"/> Requires wheelchair <input type="checkbox"/> Requires mobility aid: _____			
<input type="checkbox"/> Allergies (food, medication, other): _____		<input type="checkbox"/> Arthritis	<input type="checkbox"/> Renal
<input type="checkbox"/> Isolation Precautions: _____		<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Requires O2 in the home
<input type="checkbox"/> Cognitive Status: _____		<input type="checkbox"/> Diabetes	<input type="checkbox"/> Has portable O2 tank with them
<input type="checkbox"/> Alzheimer's disease and related dementias		<input type="checkbox"/> Infection	<input type="checkbox"/> Other: _____



Client Name: _____

D.O.B.: _____

I. DOES THE PATIENT MEET HAL ELIGIBILITY CRITERIA?		
<input type="checkbox"/> YES - 65+, stable condition, client and/or caregiver able to direct own care, can manage with 1 person transfer, special circumstance	<input type="checkbox"/> NO - explain exceptional circumstances: _____ _____	
II. HOSPITAL DISCHARGE INFORMATION		
		<input type="checkbox"/> ED <input type="checkbox"/> Inpatient
Discharge Date: _____	Discharge Time: _____	Unit/Room#: _____

III. HAL CORE SERVICES INCLUDE
<ul style="list-style-type: none"> 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
<input type="checkbox"/> Transportation Home	<input type="checkbox"/> <i>Able to be transferred to HAL vehicle by walking with one person assist or using a wheelchair</i> <input type="checkbox"/> <i>Wheelchair Accessible Vehicle (subject to availability)</i>	
<input type="checkbox"/> Medication Pick Up	<input type="checkbox"/> <i>Prescription Provided to Patient</i> <input type="checkbox"/> <i>Prescription Forwarded to Pharmacy</i>	
<input type="checkbox"/> Medical Supplies Pick Up		
<input type="checkbox"/> Grocery Pick Up		
<input type="checkbox"/> 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			
<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Pets	<input type="checkbox"/> Smoker	Comments: _____
Entrance Details: <input type="checkbox"/> Front	<input type="checkbox"/> Back	<input type="checkbox"/> Elevator	<input type="checkbox"/> Stairs

VII. PATIENT ITEMS		
Keys Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clothing/Shoes Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Money Available for Pick Up Items Listed Above? <input type="checkbox"/> Yes <input type="checkbox"/> No

VIII. FAMILY OR CAREGIVER CONTACT INFORMATION (IF APPLICABLE)		
Name: _____	Phone#: _____	Relationship: _____
Lives with Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> 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.