COMMUNITY CARE CONCEPTS OF WOOLWICH, WELLESLEY & WILMOT

Home At Last Referral Form

Please phone Community Care Concepts with all new referrals:
519-664-1900
Toll Free-1-855-664-1900
Fax 519-664-1944 (long distance from Cambridge, Guelph Fergus, Mount Forest Palmerston)

Patient information/addressograph goes here:
(must include patient name, address, phone number, date of birth, gender, and name of doctor)

To be fully completed and faxed between 08:00a.m. and 13:00p.m. the day of discharge once the patient has indicated that he/she would like to use the service.

MUST ALLOW A MINIMUM OF 3 HOURS TO ARRANGE SERVICE
SERVICE IS AVAILABLE MONDAY TO FRIDAY EXCLUDING STATUTORY HOLIDAYS

Eligibility: Proceed with referral if all boxes are checked.

- ❑ Valid Ontario health card
- ❑ 55 years+ (or special needs)
- ❑ Requires **both** the transportation and the settling in component of the program
- ❑ Able to direct own care and stable medical condition (may include foley catheter, colostomy, feeding tube, dressings, management of medications, light personal care, oxygen, managed diabetes)
- ❑ Ambulatory – able to weight bear and manage stairs with minimal one-person assist
- ❑ No threat to the safety of self or workers/volunteers (ie: active mental health concerns, aggression)

Patient Pick-Up Information:

- ❑ Grand River Hospital — Patient Unit/Room #: _____
- ❑ St. Mary's General Hospital — Patient Unit/Room #: _____
- ❑ Cambridge Memorial Hospital — Patient Unit/Room #: _____
- ❑ Guelph General Hospital — Patient Unit/Room #: _____
- ❑ Louise Marshall Hospital — Patient Unit/Room #: _____
- ❑ Groves Memorial Hospital — Patient Unit/Room #: _____
- ❑ Palmerston District Hospital — Patient Unit/Room #: _____
- ❑ Other _____ — Patient Unit/Room #: _____

Will patient require a wheelchair to get from unit to vehicle? ❑ No ❑ Yes

Date of admission: _____

Expected date of discharge: _____ Expected time of discharge: _____

Does the patient have any special travel precautions (ie: sternal precautions)?

❑ No ❑ Yes If Yes, please specify: _____

Was this patient's discharge moved up due to the availability of Home At Last?

❑ No ❑ Yes If yes, estimated number of days ____ or hours ____

Patient Information:

Patient diagnosis: _____

Reason for referral: _____
Allergies: _____

Infectious Diseases (e.g. MRSA, VRE etc.) ❑ No ❑ Yes If yes, please specify any precautions that need to be taken by worker: _____

Mobility: Independent❑ Gait Aid Required: ❑ No ❑ Yes Specify: _____
Comfortable with a male home service worker? ❑ No ❑ Yes

Smoking in home: ❑ No ❑ Yes Language(s) spoken: _____
Pets in home: ❑ No ❑ Yes Type/Details: _____

Type of residence: ❑House ❑ Apartment/Condo ❑Townhouse
Lives: ❑Alone ❑ With family Other: _____

Discharge Information:

Does the patient have the following: Clothing ❑ No ❑ Yes Shoes ❑ No ❑ Yes
Key to the home ❑ No ❑ Yes Apt. code: _____
Food for 1 to 2 meals ❑ No ❑ Yes
Will groceries need to be picked up: ❑ No ❑ Yes
Does the patient have money for groceries: ❑ No ❑ Yes
Arrangements need to be made for medication pick up: ❑ No ❑ Yes
If yes, prescriptions faxed to: _____
Address and telephone of pharmacy: _____
Does the patient have money for prescriptions: ❑ No ❑ Yes
Does the patient require oxygen in the home: ❑ No ❑ Yes

Any related information or instructions needed by the Home At Last worker to settle in the patient *(to be hand written by discharge planner)*:

Family/Caregiver: ❑ not applicable

Caregiver Information:

Name: _____ Relationship: _____
Address: _____ Cell/Phone: _____

Emergency contact during the day if different from above:

Name: _____ Relationship: _____
Address: _____ Cell/Phone: _____

Community Support Information:

Is patient going home with CCAC services: ❑ No ❑ Yes

Name of CCAC Case Manager, if known: _____ Phone: _____

Is patient being discharged with an Intensive Geriatric Service Worker? ❑ No ❑ Yes

Name of IGSW worker, if known: _____

Are supplies and equipment required: ❑ No ❑ Yes Specify: _____

Have supplies/equipment been delivered: ❑ No ❑ Yes Specify: _____

Name & Phone of business providing supplies/equipment: _____

Existing Community Support Services: (ie: Meals on Wheels, Homemaking, Assisted Transportation, Adult Day Program, Friendly Visiting)

Name of Agency: _____ Service Provided: _____

Name of Agency: _____ Service Provided: _____

Follow-Up Information:

Does the patient's family Doctor or Family Health Team need to be informed that the patient is home from the hospital? ❑ No ❑ Yes

If yes, name of Doctor/Family Health Team: _____

Phone Number: _____ Fax Number: _____

Completed by: _____ Date: _____

Telephone/Pager #: _____ Extension: _____

Return fax number for confirmation: _____

Faxed Community Care Concepts : **519-664-1944 (Long distance from Cambridge, Guelph, Fergus, Mount Forest and Palmerston)**

Date: _____ Time: _____

CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I authorize the disclosure of my personal and health information by the hospital stated above to Community Care Concepts as part of the Home At Last Program required for the delivery of services, care and treatment specific to me. I also authorize Community Care Concepts through the Home At Last Program to contact my family or caregiver identified on this form for program evaluation. I understand that I can revoke this consent at anytime.

_____ _____

Patient Signature Date