PATH
Priority Assistance to Transition Home
East & West Parry Sound

Referral Form

Referrals are accepted 5 days per week
(Monday—Friday: 9 am—4 pm)
Fax completed form to PATH Office: 1.**705.746.8139**
Tel: 1.705.746.5102 or 1.888.746.5102

Hospital Patient Label

- Transportation Home • Attendant Settling-In Service • In-Home Safety Assessment
- PATH Coordinator follow-up call to client & referrals to other community services as required

Patient meets PATH Eligibility Criteria? 65+ or 55 + with exceptional circumstances, stable condition, client and/or caregiver able to direct own care, can manage with 1 person transfer

☐ Yes Exceptional circumstances _____

P**atient or Substitute Decision-Maker has given verbal consent** to collect, use and disclose information?

☐ Yes ☐ No

Hospital Discharge Information

Discharge Date:	**Form Completed By:**
Discharge Time:	**Title:**
Unit/Room#:	**Phone/Cell:**

Source Hospital: ☐ **HSN** (Sudbury) ☐ **NBRHC** (North Bay) ☐ **MAHC** (Huntsville) ☐ **WPSHC** (Parry Sound) ☐ **WNGH** (West Nipissing)

Client Information

Name:	**D.O.B.:**	**Health Card#:**	**Ver Code:**
Destination Address:		**Town:**	
Phone #:	**Language:** ☐ **English**	☐ **Other(s):**	

General Medical Condition

Main Reason for Hospitalization _____

Known Conditions: ☐ Arthritis ☐ Cardiovascular ☐ Diabetes ☐ Infection ☐ Renal ☐ Other

Cognitive Status/Mental Health Concerns:

Isolation Precautions: ☐ No ☐ Yes—Specify:

Allergies (food, medication, other): ☐ No ☐ Yes—Specify:

Mobility: ☐ Independent ☐ Unable to climb stairs ☐ Requires mobility aid: ____Cane ____Walker ☐ Wheelchair ☐ Bariatric Wheelchair

Oxygen: ☐ Requires O^2 in the Home ☐ Has portable O^2 tank with them

Family or Caregiver Contact Information (if applicable)

Name 1:	**Phone#:**	**Relationship:**
Lives with Patient?: ☐ **Yes** ☐ **No**	**Contacted?** ☐ **Yes** ☐ **No**	**Comments:**
Name 2:	**Phone:**	**Relationship:**
Lives with Patient?: ☐ **Yes** ☐ **No**	**Contacted?** ☐ **Yes** ☐ **No**	**Comments:**

Environmental Factors

Lives Alone? ☐ **No** ☐ **Yes**	**Stairs At Entrance?** ☐ **Yes** ☐ **No**
Pets in Home? ☐ **No** ☐ **Yes** - Describe:	
Smoker?: ☐ **No** ☐ **Yes**	**Access to home will be clear?** ☐ **Yes** ☐ **No** (i.e. snow removed)

Checklist - PATH Optional Services Requested			**Comments:**
Transportation Home	☐ **Yes**	☐ **No**	
To include senior care provider?	☐ **Yes**	☐ **No**	
Wheelchair bound, able to transfer?	☐ **Yes**	☐ **No**	
Wheelchair bound unable to transfer?	☐ **Yes**	☐ **No**	
Medication Pick Up	☐ **Yes**	☐ **No**	
Prescription Provided to Patient?	☐ **Yes**	☐ **No**	
Prescription Forwarded to Pharmacy?	☐ **Yes**	☐ **No**	
Medical Supplies Pick Up	☐ **Yes**	☐ **No**	
Grocery Pick Up	☐ **Yes**	☐ **No**	
Frozen Meal (MOW)	☐ **Yes**	☐ **No**	**Special Diet:**

Client Items

Keys Available? ☐ **Yes** ☐ **No** **Clothing/Shoes Available?** ☐ **Yes** ☐ **No** **Money Available for Items above?** ☐ **Yes** ☐ **No**

LHIN Home & Community Care Client Information

Pre-admission LHIN Home & Community Care Client? ☐ **Yes** ☐ **No**

New LHIN Home & Community Care Client? ☐ **Yes** ☐ **No**

Care Coordinator Name: _____

Tel: _____

LHIN Home & Community Care Services: _____ Start Date: _____

Community Support Services: Name of Agency: _____ Tel: _____

Services Requested: _____ Start Date: _____

Additional Information

Please provide additional information that would assist the PATH Attendant to support the client to settle in at home.