# STEPPING STONES REFERRAL AND FUNCTIONAL ASSESSMENT

CENTRALIZED REFERRAL MANAGEMENT
CRM is a division of Bellwoods.

The **Stepping Stone Project** (TSSP) at LOFT's John Gibson House in downtown Toronto, was launched in 2008 in partnership with the Centre for Addiction and Mental Health and Toronto's five downtown hospitals. The goal was to help address the challenges of transitioning seniors with history of mental health illness back to the community, who were medically ready for discharge, but no longer had an appropriate or safe discharge destination due to need for affordable and supportive housing. Twelve transitional units at John Gibson House were dedicated to this population, providing that supportive, affordable environment along with services that promoted the learning or relearning of the life skills they would need to live independently. The support is individualized, patient-centred and addresses the unique needs of the patient, allowing them to recover their dignity, independence and quality of life and prepare for their next community housing destination – some to complete independence, others do best in one of LOFT's seniors supportive housing programs and are transitioned there, and some become permanent residents of John Gibson House

**FORM INSTRUCTIONS:**

1. Please fill in all fields. Incomplete information will delay processing.
2. Use the latest version of this form from http://bellwoodscentres.org/centralized-referral-management/
3. Email completed form to crm.team@bcclsp.org (PREFERRED) or fax to 365-300-5758 (Toronto Area)
4. Get Detailed Instructions and help for this form here.

**IF YOU ARE USING A COMPUTER-FILLABLE FORM, SAVE YOUR ANSWERS (FILE-SAVE)(CTRL-S ON WINDOWS)(COMMAND-S ON MAC)**

Please contact CRM at 416-447-1224 for further information. Office hours are from 8:30 am to 4:30 pm Monday to Friday.

## REFERRAL PROCESS

1. **COMPLETE ALL SECTIONS** OF THIS FORM. MISSING INFORMATION COULD DELAY MATCHING.
2. **EMAIL** crm.team@bcclsp.org OR FAX 365-300-5758 THE REFERRAL TO CENTRALIZED REFERRAL MANAGEMENT (CRM).
3. CRM TEAM WILL REACH OUT TO YOU WITHIN 1- 3 BUSINESS HOURS. YOU WILL BE **PROVIDED WITH INFORMATION ON NEXT STEPS** FOR EACH POSSIBLE OUTCOME –CONFIRMED INITIAL MATCH TO STTP; INELIGIBLE; WAITLISTED; OR DELAY MATCHING DUE TO NEED FOR ADDITIONAL INFORMATION. PLEASE FEEL FREE TO CALL OR EMAIL IF YOU DO NOT RECEIVE SUCH AN EMAIL OR CALL WITHIN 1 BUSINESS DAY.
4. THE REFERRAL WILL ONLY BE FORWARDED TO THE STTP TEAM ONCE A VACANCY HAS BEEN IDENTIFIED, PLEASE FEEL FREE TO CONNECT WITH THE CRM TEAM IF YOU REQUIRE INFORMATION ON THE WAITLIST OR IF THERE IS A NEED TO CANCEL THE REFERRAL.

## 1. PATIENT

| FIRST NAME | MIDDLE NAME | LAST NAME | DATE OF BIRTH | GENDER (F/M/NON-BINARY) |
|---|---|---|---|---|
| | | | 0000 00 00 | - |

| PREADMIT ADDRESS | CITY | POSTAL CODE | LIVE ALONE? |
|---|---|---|---|
| | | | - |

| HEALTH CARD NUMBER (WITH VERSION) | PLANNED DISCHARGE DATE |
|---|---|
| | 0000 00 00 |

## 2. REFERRAL SOURCE INFORMATION

| ORGANIZATION | YOUR NAME | TITLE | DATE |
|---|---|---|---|
| | | | 0000 00 00 |

| PHONE | EMAIL | CONTACT PREFERENCE |
|---|---|---|
| | | - |

## 3. INFORMATION SHARING, COMMUNICATION, AND LANGUAGE

| DOES THE PATIENT SPEAK ENGLISH? | IS THE PATIENT'S FIRST LANGUAGE FRENCH?* | IS AN INTERPRETER NEEDED? | LANGUAGE |
|---|---|---|---|
| - | - THERE ARE SITES SPECIFICALLY CATERING TO FRENCH-SPEAKING PATIENTS | - | |

HAS THE PATIENT BEEN DEEMED INCAPABLE OF MAKING PERSONAL CARE DECISIONS? -

| VISION | AIDS USED | HEARING | AIDS USED |
|---|---|---|---|
| - | | - | |

## 4A. PRIMARY SUPPORT (FRIEND/FAMILY/OTHER)

| FIRST NAME | LAST NAME | PHONE | RELATIONSHIP |
|---|---|---|---|
| | | | |

| EMAIL | DOES THIS PERSON LIVE WITH PATIENT? |
|---|---|
| | YES |

**EMERGENCY CONTACTS OTHER THAN PRIMARY SUPPORT**

| | NAME | CONTACT # | RELATIONSHIP |
|---|---|---|---|
| 1 | | | |
| 2 | | | |

## 4B. PROFESSIONAL CIRCLE OF CARE

| PRIMARY DOCTOR (GP) | PHONE |
|---|---|
| | |

| PSYCHIATRIST | PHONE |
|---|---|
| | |

OTHER SUPPORTS

- ✓ ☐ BSS/BSTR
- ☐ CASE MANAGEMENT
- ✓ ☐ HOME & COMMUNITY CARE
- ☐ HOUSING WORKER
- ☐ SPECIALISTS: (LIST)
- ☐ OTHER (LIST):

CONTACT INFORMATION AND FOLLOW-UP APPOINTMENTS

## 5. ALC DESIGNATION & DISCHARGE DESTINATION

| HAS THE PATIENT BEEN DESIGNATED ALC? | IF NO, IS PATIENT AT RISK FOR ALC? *PATIENT SHOULD BE ALC OR AT RISK FOR ALC TO QUALIFY FOR THIS PROGRAM |
|---|---|
| - | - |

IF APPLYING FOR THE STEPPING STONE PROGRAM, WHAT DOES THE PATIENT NEED AT THIS TIME/ WHAT ARE THE GOALS FOR THE STAY?

EQUIPMENT RENTAL AND MEDICATIONS

| | | |
|---|---|---|
| COULD INCOME IMPACT TRANSITION OPTIONS | - | |
| IS EQUIPMENT NEEDED? | - | HOW IS IT FUNDED? |
| IS MEDICATION NEEDED? | - | HOW IS IT FUNDED? |
| DOES PATIENT NEED SUPPLIES? (G-tube, incontinence etc.) | - | HOW ARE THEY FUNDED? |
| HOW IS HOUSING FUNDED? (i.e. OW, ODSP, CCP, GIS, OAS etc.) | | |

| HAS THE PATIENT APPLIED FOR LONG-TERM CARE AND HAS BEEN SELECTED | DATE OF LTC APPLICATION | **SUMMARY OF LTC CHOICES** (MANDATORY) |
|---|---|---|
| - | 0000 00 00 | |

IF CLIENT'S POST-RCU DESTINATION IS LTC, REFERRAL WILL NOT BE PROCESSED WITHOUT DETAILS OF ACCEPTED LTC AND EXPECTED WAIT TIMES AS OF DATE OF REFERRAL TO RCU

## 6. HEALTH STATUS (PHYSICAL, MENTAL, AND/OR SUBSTANCE ABUSE)

| DATE OF CURRENT HOSPITAL ADMIT | REASON | PREVIOUS 2 HOSPITAL ADMIT DATE IF KNOWN |
|---|---|---|
| 0000 00 00 | | |

BRIEF MEDICAL/COGNITIVE/MENTAL HEALTH HISTORY (A BRIEF OUTLINE IS REQUIRED ON THIS FORM, EVEN IF ADDITIONAL DOCUMENTATION PROVIDED WITH THE APPLICATION).

WEIGHT AND HEIGHT REQUIRED WHEN PATIENT NEEDS A HOYER OR 2-PERSON TRANSFER

| WEIGHT: - | HEIGHT: - |
|---|---|

**ALLERGIES**

☐ CONFIRMED NO ALLERGIES

**PLEASE INCLUDE THE REACTION. MAY INCLUDE SUMMARY FROM PATIENT'S CHART BUT INDICATE IF INFO IS SEPARATE.

| FOOD ALLERGIES | DRUG ALLERGIES | OTHER ALLERGIES |
|---|---|---|
| | | |

**INFECTIOUS RISKS**

☐ ISOLATION REQUIRED ☐ TB ☐ C.DIFF ☐ VRE ☐ RESPIRATORY INFECTION (RECENT) ☐ FLU SHOT ☐ MRSA+ ↘ IF YES HAS IT BEEN COLONIZED? YES

**HISTORY OF INFESTATION**

☐ NONE ☐ LICE/SCABIES ☐ BED BUGS ☐ OTHER:

| FALLS RISK | # OF FALLS IN LAST 2 WEEKS & DATE OF LAST FALL | STRATIFY OR HENDRICH SCORE (IF AVAILABLE) |
|---|---|---|
| YES | | |

| ACTIVE ADDITIONS | PROVIDE DETAILS INCLUDING SUBSTANCE AND ANY CURRENT TREATMENT | SMOKER |
|---|---|---|
| - | ***ON-SITE USE OF ALCOHOL AND NON-PRESCRIBED DRUGS ARE PROHIBITED | -<br>DOES PATIENT NEED AN ESCORT TO SMOKE?<br>- |

| IS WOUND CARE NECESSARY | PLEASE INCLUDE CURRENT WOUND CARE ORDERS |
|---|---|
| - | |

| ARE PRESSURE RELIEVING SURFACES NECESSARY. IF YES PROVIDE DETAILS | SURFACE DETAILS |
|---|---|
| - | |
| CAN PATIENT FUND THE COSTS OF THESE SURFACES | |

POST-DISCHARGE PLANNED FOLLOW-UP

| ✓ | | DETAILS | ✓ | | DETAILS |
|---|---|---|---|---|---|
| ☐ | CHEMOTHERAPY | | ☐ | REHAB PT/OT/ETC. | |
| ☐ | HEMODYALISIS | | ☐ | OTHER | |

**RCUs DO NOT PROVIDE TRANSPORTATION, ASSISTANCE WITH ARRANGING TRANSPORT OR PORTERING FOR APPOINTMENTS**

| DOES THE PATIENT HAVE A PALLIATIVE DIAGNOSIS? IF YES PROVIDE DETAILS | |
|---|---|
| - | ESTIMATED PROGNOSIS<br>ADVANCED DIRECTIVES<br>EMS PROVINCIAL SHEET (ATTACH)<br>RESOURCES AND SUPPORTS WHO FOLLOW |

| ✓ | **OTHER SPECIAL NEEDS** | ✓ | |
|---|---|---|---|
| ☐ | OXYGEN (FUNDING AND DELIVERY TO BE ARRANGED BEFORE TRANSITION) | ☐ | METHADONE – PATIENT MUST BE ABLE TO GET THEIR OWN |
| ☐ | BIPAP/CPAP –PATIENT SELF-MANAGED WITH OWN EQUIPMENT | ☐ | PERITONEAL DIALYSIS – PATIENT MUST BE ABLE TO MANAGE |
| ☐ | TRACHEOSTOMY –PATIENT MUST BE ABLE TO MANAGE | ☐ | BLOOD SUGAR TESTING |
| ☐ | SUCTIONING – LONG STANDING TRACH/SUCTION – PATIENT MUST BE ABLE TO MANAGE | ☐ | HEMODIALYSIS - PATIENT/FAMILY MUST BE ABLE TO ARRANGE ALL TRANSPORTATION |

INCLUDE A DETAILED CURRENT MEDICATION LIST/MEDICATION ADMINISTRATION RECORD. MARK ANY RECENT MEDICATION CHANGES (MARK & DATE). A SIGNED MEDICATION LIST PRIOR TO DISCHARGE WILL BE REQUIRED.

ALTHOUGH ST. HILDA'S HILLCREST AND REKAI ARE CONNECTED TO PHARMACIES, PATIENTS MUST HAVE AT LEAST 24 HOURS OF MEDS AND SUBMIT FINAL MED LISTS 3PM THE DAY BEFORE ADMIT. ALL OTHER RCUS REQUIRE THE PATIENT COME WITH THEIR OWN MEDICATION WITH A PLAN ON HOW THEY WILL GET MORE FOR THE DURATION OF THE STAY

| ✓ | **COGNITIVE STATUS** | **NOTES** |
|---|---|---|
| ☐ | ABLE TO DIRECT THEIR OWN CARE | |
| ☐ | ABLE TO EXPRESS THEIR NEEDS (I.E. HOT, COLD, TIRED) | |
| ☐ | ABLE TO FOLLOW INSTRUCTIONS | |
| ☐ | MEMORY CHALLENGES – SHORT TERM | |
| ☐ | MEMORY CHALLENGES – LONG TERM | |
| ☐ | CAPABLE OF NEW LEARNING/CARRY-OVER OF LEARNING | |
| ☐ | IMPAIRED JUDGMENT IMPACTING SAFETY | |
| ☐ | POOR INSIGHT INTO PERSONAL CARE NEEDS | |
| ☐ | NEEDS ASSISTANCE MANAGING MEDICATION | |
| ☐ | ABLE TO PARTICIPATE IN GROUP SETTINGS | |
| ☐ | OTHER COGNITIVE ISSUES THAT MAY IMPACT TRANSITION<br>IF COGNITIVELY IMPAIRED, PLEASE INCLUDE ANY FORMAL ASSESSMENT SCORES SUCH AS MOCA/MMSE/RUDAS | |

| | **BEHAVIOURAL STATUS (PATIENT SAFETY & RISK)** | *NOTE: INCLUDE CURRENT AND BEHAVIOURS NOTED IN THE LAST 2 MONTHS |
|---|---|---|
| ☐ | HISTORY HOARDING | |
| ☐ | PARANOID IDEATIONS | |
| ☐ | WANDERING | |
| ☐ | REQUIRES WANDER GUARD | |
| ☐ | REQUIRED LOCKED UNIT FOR EXIT SEEKING | |
| ☐ | REQUIRES 24/7 SUPERVISION/"SITTER" FOR SAFETY AND RISK | |

| | | |
|---|---|---|
| ☐ | REQUIRES PRIVATE ROOM DUE TO BEHAVIOURS | |
| ☐ | REQUIRES BED ALARMS OR WHEELCHAIR ALARMS IN THE COMMUNITY (AS OPPOSED TO DUE TO HOSPITAL POLICY) | |
| ☐ | REQUIRES FULL BED-RAILS DUE TO UNSAFE BED EXITING BEHAVIOURS | |
| ☐ | BRODA OR GERI CHAIR REQUIRED FOR PASSIVE RESTRAINT | |
| ☐ | SUICIDE-IDEATION | |
| ☐ | SUICIDE-ATTEMPTS | |
| ☐ | SELF-HARM | |
| ☐ | AGGRESSION – PHYSICAL | |
| ☐ | AGGRESSION – VERBAL | |
| ☐ | FIRE SETTING | |
| ☐ | CARELESS SMOKING | |
| ☐ | ASSAULT – SEXUAL | |
| ☐ | ASSAULT –PHYSICAL | |
| ☐ | DESTRUCTION OF PROPERTY | |
| ☐ | SEXUAL ACTING OUT | |
| ☐ | OTHER BEHAVIOURS THAT MAY IMPACT TRANSITION | |

**FUNCTIONAL STATUS**

**BED MOBILITY**

☐ INDEPENDENT ☐ REQUIRES SUPERVISION ☐ ONE-PERSON ASSISTANCE ☐ TWO-PERSON ASSISTANCE

☐ ABLE TO IDENTIFY NEED FOR REPOSITION FREQUENCY OF REPOSITION:

**WEIGHT-BEARING – CANNOT BEAR WEIGHT ON**

☐ LEFT LEG ☐ RIGHT LEG

☐ LEFT ARM ☐ RIGHT ARM

RE-ASSESSMENT PLAN

**TRANSFER**

-

☐ ONE-PERSON ASSISTANCE ☐ USES SASKA-POLE ☐ MECHANICAL LIFT – HOYER

☐ TWO-PERSON ASSISTANCE ☐ BED-BOUND ☐ MECHANICAL LIFT – SIT TO STAND LIFT

DOES THE PATIENT HAVE EQUIPMENT? -

**SITTING TOLERANCE**

**MOBILITY**

Independent With No Aid

**MOBILITY AID USED BY PATIENT:**

☐ CANE ☐ CRUTCHES ☐ 2-WHEELED WALKER ☐ ROLLATOR WALKER ☐ OTHER WALKER ☐ MANUAL WHEELCHAIR ☐ POWER WHEELCHAIR

WIDTH OF WHEELCHAIR:

**STAIRS:**

-

STAIRS AT DISCHARGE DESTINATION:

**DRESSING/GROOMING**

✓ **UPPER EXTREMITY**

-

☐ CUEING
☐ RELUCTANT
☐ DEPENDENT

✓ **LOWER EXTREMITY**

-

☐ CUEING
☐ RELUCTANT
☐ DEPENDENT

**BATHING**

-

☐ CUEING
☐ RELUCTANT
☐ DEPENDENT

**TOILETING-BLADDER**

**CONTINENT**

☐ INDEPENDENT
☐ ASSISTANCE WITH TRANSFER/MOBILITY
☐ ASSISTANCE WITH SETUP(BED PAN, ETC)

**INCONTINENT**

-

**CATHETER USE**

-

**CATHETERIZATION NEEDS**

☐ IN/OUT CATHETER
☐ INDWELLING
☐ CONDOM CATHETER
☐ LEG-BAG
☐ BLADDER SCANS

INCONTINENCE STATUS AND PLAN AT TRANSFER (CATHETER IN-SITU, DATE NEEDS TO BE CHANGED ETC.)

**TOILETING-BOWELS**

**CONTINENT**

-

**BOWEL ROUTINE WITH:**

-

**INCONTINENT**

-

**OSTOMY**

-

PLEASE NOTE, PATIENT WILL NEED TO HAVE ALL THEIR OWN INCONTINENCE OR OSTOMY SUPPLIES

**FEEDING**

| ✓ | FEEDING | ✓ | PREFERRED DIET | ✓ | REQUIRED DIET (PRESCRIBED) | ✓ | DENTITION/SWALLOW | ✓ | DIET/INTAKE |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | INDEPENDENT | ☐ | NO PREFERENCE | ☐ | LOW PROTEIN | ☐ | FULL DENTITION | ☐ | GASTRONOMY TUBES (NO NGS) |
| ☐ | CUEING/ASSISTANCE/SETUP | ☐ | VEGAN | ☐ | HIGH PROTEIN | ☐ | PARTIAL DENTITION | ☐ | DIETARY RESTRICTIONS |
| ☐ | DEPENDENT | ☐ | VEGETARIAN | ☐ | RENAL DIET | ☐ | DIFFICULTY CHEWING | ☐ | **SPECIALITY INTAKE** |
| ☐ | FAMILY ASSIST DEPENDENT PATIENT | ☐ | KOSHER | ☐ | LOW SODIUM | ☐ | NEEDS MODIFIED TEXTURES | ☐ | TPN |
| | | ☐ | GLUTEN FREE | ☐ | FOOD ALLERGIES (SEE LIST) | ☐ | DIFFICULTY SWALLOWING | ☐ | IV FLUIDS |
| | | | | | | ☐ | CUEING FOR SWALLOWING | ☐ | G-TUBE |
| | | | | | | | | ☐ | NG-TUBE |

☐ OTHER (EXPLAIN BELOW)

**ADDITIONAL NOTES**

NOTE: PATIENT WILL NEED TO HAVE ALL THEIR OWN SPECIALTY FEEDING SUPPLIES AND EQUIPMENT. PATIENT MAY NEED TO ARRANGE THEIR OWN FOODS AT SOME SITES.

**MEDICATION**

- ☐ INDEPENDENT
- ☐ REQUIRES MEDICATION REMINDERS
- ☐ REQUIRES ADMINISTRATION OF ORAL MEDS
- ☐ REQUIRES ADMINISTRATION OF INJECTIONS
- ☐ REQUIRES ADMINISTRATION OF IV MEDS
- ☐ REQUIRES PRN MEDICATIONS

For injections and IV, please clarify what will be administered and route (IV line, butterfly catheter etc.).

*Family will need to make arrangements for all medications and administration supplies before transition

**iADLS – HOUSE CLEANING**

-

**iADLS – COOKING**

-

☐ SUPPORTERS COULD PROVIDE MEALS IF MEALS NOT PROVIDED
☐ WILLING TO CONSIDER MEALS-ON-WHEELS FOR MEALS

**iADLS – SHOPPING**

-

**iADLS – FINANCE**

-

**iADLs – TRANSPORTATION**

-

*Please note, family will be responsible for transportation to and from appointment while in RCU for ReCharge, the need will need to be explored

| **LEGAL HISTORY** IS CLIENT CURRENTLY UNDER THE ORB? - | FOBS CASEMANAGER | FOBS OUTPATIENT PSYCHIATRIST | INDEX OFFENCE |
|---|---|---|---|

## 7. CONSENT TO SHARE INFORMATION

**Referral Source to review this with the patient or their designate (SDM, POA, PGT etc.)**

- Patient information contained within this form will be shared with the Health Service Providers (HSP) for the Reintegration Care Model (RCM) Program for the purpose of arranging and providing services only.
- Patient and caregiver privacy will be respected and be maintained according to the guidelines within the Ontario Personal Health Information Protection Act (PHIPA) with respect to the collection, use, disclosure, maintenance and disposal of personal health information (PHI).

| WHO IS CONSENTING TO SHARE INFORMATION (ADD RELATIONSHIP TO PATIENT) | DATE OF CONSENT | CONSENT COMPLETED BY (NAME & ROLE OF STAFF ) |
|---|---|---|
| - | 0000 00 00 | |

## 8. FORM COMPLETED BY

| | | | |
|---|---|---|---|
| 1 | | 4 | |
| 2 | | 5 | |
| 3 | | 6 | |