Ontario Health atHome

Client Name: _____

DOB: _____ BRN: _____

Phone: _____

SDM: _____

SDM Phone: _____

Retirement Home Service Information

☐ New Referral by Retirement Home ☐ Hospital Admission from Retirement Home ☐ Hospital Discharge to Retirement Home

☐ Hospital Discharge for existing Retirement Home Patient: ☐ Patient Status Unchanged or ☐ Patient Status Changed (see below)

Retirement Home:		Contact Name:	
RH Phone Number:	Fax Number:		Pt Phone Number:
Room #:	Unit(if applicable):		Locked Unit: ☐Yes ☐No ☐N/A
Meal Times	Breakfast:	Lunch:	Dinner:

Mandatory Information – services provided by retirement home Attachment ☐ Yes ☐ No

Current patient retirement home care plan based on purchased services(Retirement Home to complete):

**note: non-disclosure of purchased services will default to basic service authorization, when applicable, for OHaH funded services*

Dressing AM	☐Cue ☐Assist ☐PRN ☐N/A	Incontinence care	☐Cue ☐Assist ☐PRN ☐N/A
Dressing PM	☐Cue ☐Assist ☐PRN ☐N/A	Medication management	☐Cue ☐Assist ☐PRN ☐N/A
Personal Care AM	☐Cue ☐Assist ☐PRN ☐N/A	Tray service*	☐Cue ☐Assist ☐PRN ☐N/A
Personal Care PM	☐Cue ☐Assist ☐PRN ☐N/A	Feeding*	☐Cue ☐Assist ☐PRN ☐N/A
Grooming AM	☐Cue ☐Assist ☐PRN ☐N/A	Overnight check-in*	☐Cue ☐Assist ☐PRN ☐N/A
Grooming PM	☐Cue ☐Assist ☐PRN ☐N/A	Physio Therapy	☐Cue ☐Assist ☐PRN ☐N/A
Toileting AM	☐Cue ☐Assist ☐PRN ☐N/A	Portering*	☐Cue ☐Assist ☐PRN ☐N/A
Toileting PM	☐Cue ☐Assist ☐PRN ☐N/A	Other:	☐Cue ☐Assist ☐PRN ☐N/A

Bath(s) Purchased: ☐ Yes ☐No Bath Day(s): M T W Th F S Su Bath Time(s): AM/PM

Patients Current Functional and Cognitive Status

Palliative approach to care initiated: ☐ Yes ☐ NA

Care Conference Required: ☐ Yes ☐ No

I=Independent; **C=**Cueing; **S**=Supervision; **Ax1**=1 person assist**; Ax2**=2 person assist**; Mech**=Mechanical Assist**; NA**=Not Applicable

ADL's	**RH**	**CCC**	**ADL's Cont.**	**RH**	**CCC**
Toileting		☐No Change	Feeding		☐No Change
Bathing		☐No Change	Transfers		☐No Change
Dressing		☐No Change	Mobility		☐No Change

Continence	**RH**	**CCC**	**Identified Behaviours**	**RH**	**CCC**
Bladder Incontinence	☐Yes ☐No	☐Yes ☐No	Resisting care	☐Yes ☐No	☐Yes ☐No
Bowel Incontinence	☐Yes ☐No	☐Yes ☐No	Agitation	☐Yes ☐No	☐Yes ☐No
Incontinence managed	☐Yes ☐No	☐Yes ☐No	Exhibiting signs of aggression	☐Yes ☐No	☐Yes ☐No
Incontinence management plan details:			Exit seeking	☐Yes ☐No	☐Yes ☐No
			Behaviour Management Plan ***Attach if Yes**	☐Yes ☐No	☐Yes ☐No

Cognition	**RH**	**CCC**	**Other Risk or Training required, describe details below:**
Dementia	☐Yes ☐No	☐Yes ☐No ☐ No Change	
Able to direct care	☐Yes ☐No	☐Yes ☐No ☐ No Change	
Delirium	☐Yes ☐No	☐Yes ☐No ☐ No Change	

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To be completed by OHaH. * *Note: Care Plan will be reviewed by Community Care Coordinator and adjusted as required to reflect patient need following assessment*		**Authorized services**: ☐ **PSW** ☐ **Therapy** ☐ **Nursing** **Patient Assessment Attached:** ☐ **Yes** ☐ **No**
Completed by:	Position:	Contact#:

Addition Comments (if needed)

Ontario Health atHome Fax Numbers

Intake	519 883 5550
Area Hospitals	
Cambridge Memorial Hospital	519 621 4446
Freeport Hospital	519 894 8372
Grand River Hospital	519 743 9783 (9A1)
	519 749 4364 (J518)
Groves Memorial Hospital	519 843 7426
Guelph General Hospital	519 767 2965
Homewood Health Centre	519-571-3973
Louise Marshall Hospital	519 323 4122*
Palmerston District Hospital	519 343 4202*
St. Joseph's Hospital	519 823 9960
St. Mary's Hospital	519 749 6800
Sunnyside	519 571 3969

**Note:* *These are not OHaH fax machines; please make sure the Care Coordinator is aware a fax is being sent.*