Ontario Health atHome

Long-Term Care Home Referral for Services

To accompany ALL requests for Nursing, Wound Care Specialist or Speech Language Pathologist for Swallowing Assessment

Contact Ontario Health atHome at **1-800-810-0000** Fax: 905-639-8704 or 1-866-655-6402

Patient Name________________________________ HCN_________________________ VC_____ DOB___________________
Facility and Address____ City________________________________
Ward__________________________________ Room____________ Facility Phone____________________________________

PATIENT INFORMATION

Is the patient competent to make treatment decisions? Yes No If no, see below:

NOTE: Substitute Decision Maker (SDM) must be able to make treatment decisions.
SDM Name:____
SDM Contact #:___________________________________ Date Notified:____

Consent Given? Yes No ***If no – do not send referral****
SDM wishes to be present for assessment/consultation? Yes No
Is English the patient's preferred language? Yes No
If no, what language does the patient understand:____
Does the patient use a communication aid? Yes No Specify:____

Other Concerns: MRSA VRE C diff Other:____
Is the LTC home currently in outbreak? Yes No Is the outbreak on patient's unit/floor? Yes No

SERVICE REQUESTED

Speech Language Pathology

Present Diet Texture:__________________________________ Fluid:____
Reason for Referral____

Patient is unable to access services outside the home i.e. outpatient clinic due to their condition? Yes No
Has patient been assessed by your dietician? Yes No ***(include dietitian interventions & consult notes with referral)***
Swallowing assessment recommended by clinician? Yes No Referred by: Dietician MD Nurse
Have directives left by SLP previously been followed? Yes No Specify:____
Does patient have a weight loss in the past 2 months? Yes No Amount:____
Describe patient's intake/appetite: Good Fair Poor
Is there a history of aspiration, congestion and/or pneumonia? Yes No Specify:__________________________________
Is the patient "pocketing" food? (i.e. food/residue remains in mouth after a swallow) Yes No
Is the patient a self-feeder? Yes No
Is the patient able to follow directions? Yes No
Is the patient able to sit and maintain position? Yes No
Is the patient combative or have any behavior issues? Yes No

Describe Patient's signs of difficulty:
Throat clearing with: Liquid Food Pills/Medication
Coughing with: Liquid Food Pills/Medication
Choking with: Liquid Food Pills/Medication

Patient Name:____ **HCN:**_______________________________________

Nursing for teaching IV (up to 3 visits)

Teaching/consultation required for e.g. IV:____

LTC home has explored all other supports including the home's (or corporate/region) clinical educator, pharmacy, vendor, Nurse Practioner Led Outreach Team and contacted agencies? Yes No

LTC home's clinical educator or DOC/charge nurse(s) would be present for the training? Yes No

LTC home has a plan for the ongoing skills maintenance/training? Yes No

Medical equipment (e.g. pump), supplies and medications are in place, if applicable? Yes No

Please do no send referral until the above are in place

Wound Consult Assessment (1-2 visits)

Location of wound(s):____

Wound measurements (LxWxD):____

Dressing treatment/frequency:____

Reason for wound consult nurse assessment:____

Please do no send referral until the above are in place

Additional Information:

____ ____

Signature of LTCH staff completing referral | Date

____ ____

Print Name/Designation | Number/Extension for Unit