REFERRAL FORM FOR SUPPORTS FOR DAILY LIVING

SUPPORT FOR DAILY LIVING REFERRAL FORM (PLEASE CHECK)		
☐ For patients currently in the Hospital Fill out section A,B,C,E,F,G,H (exclude section D)	☐ For clients in community from CCAC Fill out section A,B,D,E,G,H (exclude section C)	☐ For clients from SDL/other CSS agencies Fill out section A,B,E,F,G,H (exclude section C & D)

Please complete and fax to (905) 337.0770 or sdlreferrals@centralregistry.ca or submit online at www.centralregistry.ca

A. Client Contact Information

Client First Name:		**Client Last Name:**	
Date of Birth: (DD/MM/YY)		**Ontario Health Card Number & Version:**	
Gender:	☐ M ☐ F		
Home Phone Number:		**Home Address:**	
Alternate Contact & Relationship to Client:		**Alternate Contact Number:**	

B. Referral Contact Information

First & Last Name:		**Organization:**	
Date of Referral: (DD/MM/YY)		**Phone & Ext:**	

C. Hospital Information (If being referred from hospital please fill out the following section)

Hospital Admission Date: (DD/MM/YY)		**Reason for Hospital Admission:**	
Is Patient currently designated ALC?	☐ Yes ☐ No	**Anticipated Discharge Date: (DD/MM/YY)**	
Current or Recent Infectious Disease(s)?	☐ Yes ☐ No	**Type of Infectious Condition + Precautions Required:**	
Prior to hospitalization who was the patient serviced by?	☐ CCAC ☐ Links to Care ☐ SDL ☐ Other/Private		
Patient discharge summary or OT/PT Notes Attached	☐ Yes ☐ No	**Is patient aware of the referral to SDL and given consent?**	☐ Yes ☐ No

D. CCAC Information (If being referred by CCAC, please fill out the following section)

CCAC Client Reference Number:		**CCAC Caseload:**	
PSW hours serviced by CCAC (per day or week):		**Date of most recent RAI: (DD/MM/YY)**	
Is client currently serviced by CCAC:	☐ Yes ☐ No	**Is client currently on LTC waitlist?**	☐ Yes ☐ No
Identify the program in which the client is serviced by?	☐ CCAC – Wait@Home Enhanced ☐ CCAC – Stay@Home	☐ CCAC – Wait@Home for LTC ☐ Restore/Convalescent care	☐ CCAC – In Home Services ☐ Other (list):

E. Reason(s) for SDL Referral

Briefly describe reason(s) for SDL referral (frequency of visits and/or availability of 24hr support). Please state why there is a need for 24/7 frequency model and why SDL is the most appropriate service: (Examples: patient lives alone + needs assistance overnight; has a history of falls + requires toileting at night; is alone all + has diabetes + requires medication support etc.).

REFERRAL FORM FOR SUPPORTS FOR DAILY LIVING

F. Assessment Information (for all referring sources to complete please)

Is the client cognitively competent to direct their own care?	☐ Yes ☐ No	**Does client have POA involved in decision-making and providing daily care direction?**	☐ Yes ☐ No
POA's Relationship:		**POA's Name & Phone:**	
Does anyone besides the client need to be present during assessment?	☐ Yes ☐ No	**If yes, Name, Phone, Relationship:**	
Does the client require translation?	☐ Yes ☐ No	**If yes, Who, Phone, Relationship:**	
RAI Assessment completed?	☐ Yes ☐ No	**Date of most recent RAI Assessment: (DD/MM/YY)**	
Assessment attached?	☐ Yes ☐ No	**What kind of RAI?**	☐ RAI-HC ☐ RAI-CHA ☐ RAI-MDS
Client to be removed from LTC waitlist?	☐ Yes ☐ No	**Consent given to share assessment:**	☐ Yes ☐ No
Is the client in need of a new residence in addition to support?	☐ Yes ☐ No	**Does the client currently reside in an SDL building or surrounding hub area?**	☐ Yes ☐ No

Please include RAI Scores below clearly

RAI Scores:	**ADL:**		**IADL:**		**CPS:**	
	MAPLE:		**CHESS:**		**TOTAL:**	

G. SDL Appropriateness (for all referral sources to complete)

SDL Eligibility Criteria	**Yes**	**No= Excluded**	**Comments**
Is the patient 65 or older?	☐	☐	
Is the patient able to be left alone between visits (i.e. does not need constant supervision by SDL service)**?**	☐	☐	
Is the patient medically stable or can the client's medical needs be met in the community? (i.e. by CCAC, GP or other)?	☐	☐	
Does the patient require approximately **1.5 hr/daily of intermittent** support or attendant care (including prompting, cuing, physical assistance, etc.)?	☐	☐	
Is the patient/family agreeable to SDL services? (**daily intermittent care**)	☐	☐	
SDL Exclusion Criteria	**Yes= Excluded**	**No**	**Comments**
Does the patient pose a risk to self or others?	☐	☐	
Does the patient's need for support with homemaking exceed the need for personal support (more IADLs than ADLs)**?**	☐	☐	
Does the patient require specialized behavioural care or mental health support not provided by this service (physically combative, verbally abusive etc)**?**	☐	☐	

REFERRAL FORM FOR SUPPORTS FOR DAILY LIVING

H. Support Summary								
Summary of Support Activities Required Throughout a 24hr Period								
Activities of Daily Living (ADLs & IADLs)	Morning Visit (7am-12pm)		Afternoon Visit (12pm-5pm)		Evening Visit (5pm-11pm)		Overnight Visit (11pm-7am)	
	Services Needed	Preferred Time	Services Needed	Preferred Time	Services Needed	Preferred Time	Services Needed	Preferred Time
Personal Hygiene	☐		☐		☐		☐	
Toileting	☐		☐		☐		☐	
Transferring	☐		☐		☐		☐	
Dressing/Undressing	☐		☐		☐		☐	
Preparing meals/ assistance with eating	☐		☐		☐		☐	
Medication reminders	☐		☐		☐		☐	
Safety Check	☐		☐		☐		☐	
Exercise/Range of Motion	☐		☐		☐		☐	
Essential Light housekeeping	☐		☐		☐		☐	

Additional Notes

****To help determine eligibility, a copy of OT/PT notes and/or medication list can be included with this form.****

Submit to:

Central Registry

Email: sdlreferrals@centralregistry.ca

Website: www.centralregistry.ca

Phone: 905.281.4443 Fax: 905.337.0770