Ontario Health atHome

Long-Term Care Home Referral for Services

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

Patient Name_____HCN_____VC _____ DOB_____
LTCH Address_____City_____
Ward_____Room_____LTCH 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 Swallowing Assessment**

Present Diet: Texture _____ Fluid _____

Reason for Referral _____

Home does not have clinician who completes swallow assessments ☐
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

Print Clear

Patient Name _____ **HCN** _____

☐ **Nursing Service Teaching for IV Administration**

Teaching/consultation required for IV administration, specify: _____

LTC home has explored all other supports including the home's (or corporate/region) clinical educator, pharmacy, vendor, Nurse Practitioner 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, pole), supplies and medications are in place, if applicable? ☐ Yes ☐ No

Note: Ontario Health atHome does not provide equipment, supplies or medication for the purpose of IV administration.

Please do not send referral until the above are in place

Additional Information:

_____ _____

Signature of LTCH staff completing referral | Date

_____ _____

Print Name/Designation | Number/Extension for Unit