***Please fill out the 2-page referral form for TCU consideration. Incomplete referrals will be returned.***

|  |  |
| --- | --- |
| Exclusion Criteria | Needs Discussion and/or Pre-Planning |
| * Acute respiratory failure or tracheostomy * Unstable behaviours requiring constant care or restraints * Acute delirium * Peritoneal Dialysis * Chest Tubes * O2 needs greater than 5L/min | * IV therapy * Bariatric patients * Extensive wounds or NPWT dressings * Hemodialysis patients * Enteral feeds * Bed-spacing of patients waiting for Freeport programs |
| **CONSENT** | |
| Substitute Decision Maker (SDM) / Power of Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_  Name Relationship to Patient Contact Information  The Transitional Care Unit at Freeport has been recommended as you no longer require acute care. Your medical and personal information will be shared with the program. You will be notified when a bed becomes available. The assigned bed may be on the Secure Unit – a protective environment that prevents residents from wandering off unit. **Patient/SDM Consent**: Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_  **Telephone Consent:** Consent From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **MEDICAL INFORMATION** | |
| Advance Directive:  Allergies:  Diagnosis:  Comorbidities:  Cognitive Impairment:  Yes Details:   No  Unable to Assess  Isolation Status: Yes (circle applicable): C. Diff / COVID-19 / CPE / ESBL / MDRP / MRSA / VRE / Other:  Positive -- Date of last swab:   Suspect  Exposed  Resolved  No isolation | |
| **BEHAVIOUR/INTERVENTIONS** | |
| |  |  |  |  | | --- | --- | --- | --- | | **BEHAVIOUR** | **YES** | **NO** | **COMMENTS/MANAGEMENT** | | Verbally / Physically / Sexually Responsive (circle applicable) |  |  |  | | Late-Day Confusion |  |  |  | | Exit-Seeking / Wandering (circle applicable) |  |  |  | | Resistant to Care |  |  |  | | Hoarding |  |  |  | | Hallucinations / Delusions (circle applicable) |  |  |  | | Substance Abuse |  |  |  | | Suicidal Ideation |  |  |  | | **INTERVENTIONS** | **YES** | **NO** | **COMMENTS** | | Medication changes in the **last 72 hours?** |  |  |  | | Use of PRNs in the **last 72 hours?** |  |  |  | | Restraint use in the **last week?** |  |  |  | | Constant Care used in the **last week?** |  |  |  | | Threat Alert? |  |  |  | | Psychogeriatric Resource Consultant involved? |  |  |  | | Behaviour Management Plan? (attach) |  |  |  | | |
| **DISCHARGE PLAN** | |
| Discharge Plan has Been Established: Yes No Describe:  Co-pay in Place: Yes No  Other: Discussion has taken place as of (date):  If patient is **ALC-LTC,** LTC application is complete and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has discussed the Refusal of Bed Offer Pathway with the patient/SDM (Name of Staff) | |
| **CURRENT FUNCTIONAL STATUS** | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Activity** | **Independent** | **Set-Up or Supervision** | **Min Assist** | **Mod Assist** | **Max Assist** | **1A or 2A** | **Not Applicable** | | **Bed Mobility** |  |  |  |  |  | 1A  2A |  | | **Transfer** (bed to chair) |  |  |  |  |  | 1A  2A |  | | **Ambulation** |  |  |  |  |  | 1A  2A |  | | **Wheelchair Mobility** |  |  |  |  |  | 1A  2A |  | | **Bathing** |  |  |  |  |  | 1A  2A |  | | **Toileting** |  |  |  |  |  | 1A  2A |  | | **Dressing** |  |  |  |  |  | 1A  2A |  | | **Feeding** |  |  |  |  |  | 1A  2A |  | | **Grooming** |  |  |  |  |  | 1A  2A |  | | |
| Weight Bearing:  Full  Partial  Toe Touch  NA Other Restrictions (i.e. sternal precautions): | |
| Bladder Continent:  Yes  Occasional Incontinence  Incontinent  Indwelling Catheter  In/Out Catheter  If yes to catheter: Type:  Size:  Date of Last Change:  Bowel Continent:  Yes  Occasional Incontinence  Incontinent Bowel Care Plan:  Yes  No  Ostomy:  Yes (attach care and supply details or describe)   No | |
| **EQUIPMENT** | |
| Collar  Splint  Cast  Brace  Bariatric Equipment  Specialty surfaces / mattress  Mechanical Lift:   Wheelchair (include sizing):   Walker (include type):  Other equipment needs: | |
| **CARE NEEDS** | |
| Diet Type:  Special Diet Concerns (i.e. fluid restrictions):  Enteral Feeding:  Yes (attach orders and supplies or describe)   No | |
| Wound(s):  Yes  No Is Wound Care Nurse Involved:  Yes (attach most recent consult/orders)  No  Location:  Stage: | |
| Drains / Tubes (i.e. nephrostomy):  Yes  Type:  (attach management plan or describe below)  No    IV:  Yes  Peripheral Gauge   PICC Central Line Type:  Location:   No | |
| Oxygen:  Yes Flow Rate:  Delivery Method:   No  Circle if applicable: BIPAP / CPAP / APAP  Yes (Patient is to bring own equipment to Freeport Campus) | |
| **UPCOMING APPOINTMENTS** *(List appointments not captured in Cerner below)* | |
|  | |
| **OTHER INFORMATION** *(Non-Cerner Hospitals send H&P, 24 hours of Nursing & Allied Notes, MARS, BPMH, Consult Notes)* | |
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| **Completed By:** | Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Role:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Referring Program:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Contact Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |