WRHN @ Chicopee
Waterloo Regional Health Network

Patient Label

WRHN @ Chicopee Transitional Care Unit (TCU) Referral Form

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

• 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 Chicopee programs

Informed Patient/SDM

The patient/SDM was informed that the Transitional Care Unit at WRHN @ Chicopee has been recommended as you no longer require acute care. 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.

Please check: Yes_____ No _____

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 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)

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TCU Referral Form (Page 2 of 2)

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 WRHN @ Chicopee)

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)*

Completed By:	Name:	Role:	Referring Program:	Contact Number: