WRHN @ Chicopee
Waterloo Regional Health Network

Patient Label

WRHN @ Chicopee Transitional Care Unit (TCU) Referral Form

Fax completed forms to (519)894-8362

Please complete all sections. Incomplete forms will not be processed

Exclusion Criteria	Needs Discussion and/or Preplanning
• 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 for other Chicopee programs

Informed Patient / SDM Consent

The Transitional Care Unit at Chicopee has been recommended as you/your next of kin no longer require acute care. Patients will be expected to participate in transitional programming, with the goal of maintaining or improving current functional status to help facilitate a successful transition to future living environments or additional programming. You will be notified when a bed becomes available. The assigned bed may be on the Secure Unit – a protective environment designed to prevent residents from wandering off unit unattended.

Patient/SDM	Witness

Contact Information

Next of Kin/Primary Contact:	Relationship: Spouse ☐ SDM ☐ POA ☐ Other ☐
Telephone:	
Other Emergency Contacts:	

Medical Information

Medically Stable: Yes ☐ No ☐	ALC Designation: Yes ☐ No ☐ ALC Date:
Primary Diagnosis	
Relevant Comorbidities	
Active Medical Issues	
Follow up Appointments/Imaging/Pending Investigations	

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Clinical Information			
Vital Signs	Height Weight		Code Status
Allergies: Please specify None ☐			
Isolation Status: MRSA ☐ VRE ☐ ESBL ☐ CPE ☐ CDIFF ☐ DROPLET ☐			
Hearing Impaired: Yes ☐ No ☐	Hearing Aids: Yes ☐ No ☐	**Visually Impaired** Yes ☐ No ☐	Glasses: Yes ☐ No ☐
Speech Communication:	Language:		
Adequate: Yes ☐ No ☐	Aphasia/Dysarthria ☐	Difficulty Communicating ☐	Unable to Communicate ☐
Nutrition:	Diet Type:	Enteral Feeds:	
Standard Diet: Yes ☐ No ☐	Texture:	Dentures:	
	Fluid Consistency:	Swallowing Concerns: Yes ☐ No ☐	
Bladder: Full Control ☐	Routine Toileting ☐	Occasionally Incontinent ☐	Incontinent ☐
	Foley Catheter ☐	Size:	Change Due Date:
Bowel: Full Control ☐	Routine Toileting ☐	Occasionally Incontinent ☐	Incontinent: ☐
	Date of Last BM:		
Ostomy:	Yes ☐ No ☐	Ileostomy: ☐	Colostomy: ☐
	Independent with Care ☐	Requires Assistance ☐	Total Care: ☐
IV Therapy:	Yes ☐ No ☐	Fluid/Rate	
IV Antibiotics	Yes ☐ No ☐	Frequency/Duration	
PICC Line	Yes ☐ No ☐	Length/Location	
Dialysis:	Yes ☐ No ☐	Frequency/Duration	
Skin Condition	Rashes ☐	Incision ☐	Requires q2h Positioning ☐
WNL ☐	Open Sores ☐	Dressings ☐	Requires Foot Care: ☐
	Decubitus Ulcers ☐	VAC Dressings ☐	Burns ☐
Attach supporting documentation including specific interventions: (Nursing notes, wound care direction)			
Respiratory Requirements			
Supplemental Oxygen	Yes ☐ No ☐	Route:	L/MIN
CPAP	Yes ☐ No ☐	Patient Owned:	Yes ☐ No ☐
Transitional Care Unit is unable to support oxygen requirements greater than 5L/min			

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Cognition **WNL = Within normal limits I= Impaired**					
	WNL	I	Comments		
Cognitive Function	☐	☐			
MOCA Score	☐	☐			
Ability to Retain Information	☐	☐			
Orientation (person/place/time)	☐	☐			
Responsive Behaviours:	Yes ☐	No ☐			
	Verbal ☐		Physical ☐	Sexual ☐	
	Late-day Confusion ☐		Exit- Seeking ☐	Wandering ☐	
	Delusions ☐		Hallucinations ☐	Hoarding ☐	
	Suicidal Ideation ☐		Substance Abuse ☐		
Interventions:	Medication changes **(in the last 72 hours)**			Yes ☐	No ☐
	PRN use **(in the last 72 hours)**			Yes ☐	No ☐
	Restraint use **(in the last week)**			Yes ☐	No ☐
	Constant care/increased observation **(in the last week)**			Yes ☐	No ☐
	Active Threat Alert documented (per WRHN policy)			Yes ☐	No ☐
	Historical Threat Alert documented (per WRHN policy)			Yes ☐	No ☐
	Psychogeriatric Resource Consultant involvement			Yes ☐	No ☐
	Behaviour Management Plan **(please attach)**			Yes ☐	No ☐

ADL & Mobility Function **Ind = Independent SU = Setup S = Supervision A = Assistance**					
	Ind	SU	S	A	Comments (Min/Max/Mod/Ax1/Ax2/Baseline)
Feeding	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Supine to Sit	☐	☐	☐	☐	
Bed to Chair	☐	☐	☐	☐	
Ambulation	☐	☐	☐	☐	
Stairs	☐	☐	☐	☐	

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FALLS HISTORY			
Falls History: Yes ☐ No ☐	# falls in last 7 days:		Bed/Chair Alarm Yes ☐ No ☐
	# falls in last 30 days:		Other:
Weight Bearing Status	Full ☐	Partial ☐	Non-weight bearing ☐
Current Mobility Aid None ☐	Walker ☐	Wheelchair ☐	Bed Bound ☐
Movement Restrictions			
Current Equipment Needs			
PT Assessment date:	OT Assessment date:		

Program Suitability		
Rehabilitation Goals (Allied Health to complete)	**Y**	**N**
Improve Mobility and Transfers	☐	☐
Maintain Activities of Daily Living	☐	☐
Prevention of Functional Decline	☐	☐
Fall Risk Reduction	☐	☐
Medication Management	☐	☐
Strengthening and Endurance	☐	☐
Range of Motion	☐	☐
Nutritional Support	☐	☐
Reducing Social Isolation/ Group Participation	☐	☐
Communal Dining/Living	☐	☐
Other Goals:		

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Discharge Planning		
Has discharge plan been initiated? Yes ☐ No ☐	Home independently ☐	Home w/supports ☐
Retirement Home: Yes ☐ No ☐		
Long Term Care: Yes ☐ No ☐	Crisis Approved Yes ☐ No ☐	App Complete? Yes ☐ No ☐
Other Discharge Location:		
Prior Home Care Supports: None ☐ PT ☐ OT ☐ PSW ☐ Nursing ☐		
Anticipated Discharge Concerns:		
Co-pay discussion date: NA ☐	Co-pay form completion: Yes ☐ No ☐	

Sending Facility and Unit:	**Contact information:**

Contributing Staff	Professional Designation