

Retirement Home Service Information

Client Name: _____
 DOB: _____ BRN: _____
 Phone: _____
 SDM: _____
 SDM Phone: _____

- New Referral by Retirement Home Hospital Admission from Retirement Home Hospital Discharge to Retirement Home
 Hospital Discharge for existing Retirement Home Patient: Patient Status Unchanged or Patient Status Changed (see below)

Retirement Home:		Contact Name:	
RH Phone Number:		Fax Number:	
Pt Phone Number:		Room #:	
Unit(if applicable):		Locked Unit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Meal Times	Breakfast:	Lunch:	Dinner:
Mandatory Information – services provided by retirement home Attachment <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current patient retirement home care plan based on purchased services(Retirement Home to complete):			
<i>*note: non-disclosure of purchased services will default to basic service authorization, when applicable, for HCCSS funded services</i>			
Dressing AM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Incontinence care	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Dressing PM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Medication management	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Personal Care AM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Tray service*	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Personal Care PM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Feeding*	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Grooming AM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Overnight check-in*	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Grooming PM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Physio Therapy	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Toileting AM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Portering*	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Toileting PM	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A	Other:	<input type="checkbox"/> Cue <input type="checkbox"/> Assist <input type="checkbox"/> PRN <input type="checkbox"/> N/A
Bath(s) Purchased: <input type="checkbox"/> Yes <input type="checkbox"/> No		Bath Day(s): M T W Th F S Su	
		Bath Time(s): AM/PM	

Patients Current Functional and Cognitive Status			Palliative approach to care initiated: <input type="checkbox"/> Yes <input type="checkbox"/> NA		
			Care Conference Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		
I=Independent; C=Cueing; S=Supervision; Ax1=1 person assist; Ax2=2 person assist; Mech=Mechanical Assist; NA=Not Applicable					
ADL's	RH	CCC	ADL's Cont.	RH	CCC
Toileting		<input type="checkbox"/> No Change	Feeding		<input type="checkbox"/> No Change
Bathing		<input type="checkbox"/> No Change	Transfers		<input type="checkbox"/> No Change
Dressing		<input type="checkbox"/> No Change	Mobility		<input type="checkbox"/> No Change
Continance	RH	CCC	Identified Behaviours	RH	CCC
Bladder Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Resisting care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incontinence managed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exhibiting signs of aggression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incontinence management plan details:			Exit seeking	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Behaviour Management Plan <i>*Attach if Yes</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognition	RH	CCC	Other Risk or Training required, describe details below:		
Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Change			
Able to direct care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Change			
Delirium	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Change			

HOME AND COMMUNITY CARE SUPPORT SERVICES

Waterloo Wellington

To be completed by WWHCCSS. * *Note:* Care Plan will be reviewed by Community Care Coordinator and adjusted as required to reflect patient need following assessment

Authorized services: PSW Therapy Nursing

Patient Assessment Attached: Yes No

Completed by:

Position:

Contact#:

Addition Comments (if needed)

WWHCCSS Fax Numbers

Intake.....	519 883 5550
Area Hospitals	
Cambridge Memorial Hospital	519 621 4446
Freeport Hospital	519 894 8372
Grand River Hospital.....	519 743 9783 (9A1)
.....	519 749 4364 (J518)
Groves Memorial Hospital	519 843 7426
Guelph General Hospital.....	519 767 2965
Homewood Health Centre	519-571-3973
Louise Marshall Hospital	519 323 4122*
Palmerston District Hospital	519 343 4202*
St. Joseph's Hospital	519 823 9960
St. Mary's Hospital	519 749 6800
Sunnyside	519 571 3969

**Note: These are not WWHCCSS fax machines; please make sure the Care Coordinator is aware a fax is being sent.*