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.***

| Exclusion Criteria | Needs Discussion and/or Pre-Planning |
|---|---|
| • Acute respiratory failure or tracheostomy<br>• Unstable behaviours requiring constant care or restraints<br>• Acute delirium<br>• Peritoneal Dialysis<br>• Chest Tubes<br>• O2 needs greater than 5L/min | • IV therapy<br>• Bariatric patients<br>• Extensive wounds or NPWT dressings<br>• Hemodialysis patients<br>• Enteral feeds<br>• 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**

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: |
|---|---|---|---|---|