

# Hospital Referral Form

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Client Name (last, first): \_\_\_\_\_

Referral Hospital: \_\_\_\_\_

Hospital Emergency Department       Hospital Inpatient Unit: \_\_\_\_\_ (specify)

Referee Name: \_\_\_\_\_ Referee Title: \_\_\_\_\_

Date of Referral (dd/mm/yy): \_\_\_\_\_ Phone #: \_\_\_\_\_

D.O.B. (dd/mm/yy): \_\_\_\_\_ OHIP #/Health Insurance: \_\_\_\_\_

Drug Coverage     ODB     Other: \_\_\_\_\_     None

Income Source: \_\_\_\_\_

Health Care System contacts (name/phone number): \_\_\_\_\_

Client's Living Situation:     Homeless     Under housed

Current Living Situation or Address: \_\_\_\_\_

Reason For Referral: \_\_\_\_\_

Primary Medical Diagnosis: \_\_\_\_\_

Other Clinical Information: \_\_\_\_\_

Medications : (if known) \_\_\_\_\_

Infectious Disease Risk:

\_\_\_\_\_ TB status \_\_\_\_\_

\_\_\_\_\_ Last PPD \_\_\_\_\_ Last CXR \_\_\_\_\_

\_\_\_\_\_ MRSA \_\_\_\_\_ VRE \_\_\_\_\_

\_\_\_\_\_ C. Difficile \_\_\_\_\_ Other \_\_\_\_\_

Daily Living Skills: Is the client independent in self care?     Yes     No

Independently mobile?     Yes     No

Assistance Required: \_\_\_\_\_

Assistive Devices (please list): \_\_\_\_\_

CCAC Referral Made:     Yes     No    Service Start Date: \_\_\_\_\_

Mental Health Issues:     Yes     No

Safety Risks:     Yes     No     Unknown

If yes, please describe symptoms or behaviours:

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Substance Use:     Yes     No

Preferred Substance(s): \_\_\_\_\_

Pattern of Use: \_\_\_\_\_

*See Second Page for Referral information, Admission Criteria, TB policy and signature.*



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## Sherbourne Health Centre's Infirmery Program

The Sherbourne Health Centre infirmery is a 24 hour/day program for homeless and under housed persons to stay when they are recovering from an acute medical condition or illness and have no place to go to adequately recuperate. It is a small health facility for all genders, designed with communal pods to allow for privacy and to meet the needs of different service users. The infirmery is a therapeutic, non-hospital environment. Nursing staff will be available 24 hours a day and linkages will be made within Sherbourne Health Centre and the community. Referrals can be made directly from hospitals, shelters, drop-ins, community outreach workers, and from individuals directly needing such care.

### General Admission Criteria

- Must have an acute medical problem and be in need of short-term recuperative care
- Must be medically and psychiatrically stable enough to receive care in a communal setting.
- Must not require acute or hospital based care
- Must be independent in self care and must be mobile.

### Referral Process

- 1) Please fax completed referrals to 416 324 4258. An Infirmery staff member will make contact to discuss the referral and clarify details if required, and if necessary may elect to make face to face contact with the person being referred.
- 2) Admission will only occur after the SHC's Infirmery staff have agreed to accept the client.
- 3) Admissions and referral processing will occur Monday to Thursday only, between the hours of 9 and 3 pm.

## Required Paperwork To Accompany Referral Form

### *FOR: Hospital In-patient Referrals*

- Discharge summary and prescription(s)
- Pertinent labs and related clinical/diagnostic studies
- Psychiatric or substance use consultations
- Pertinent social service information
- Follow up appointments of referrals
- Infectious diseases screen

### Emergency Department Referrals

- Copies of Emergency visit records
- Pertinent clinical information, laboratory data, diagnostic studies
- ID screen
- Follow up appointments/referrals

### TB Policy

As all homeless persons are at risk for TB, any person being referred with a **new cough, change in cough for 3 weeks**, or with **pulmonary symptoms** must have a **Chest X-Ray**. Any **infiltrate or unexplained pleural effusion** should be viewed as potentially suspicious for TB until proven otherwise. Such clients will not be admitted to SHC's infirmery program until **3 AFB smears** are negative, the client demonstrates clear clinical improvement or the **CXR shows definite signs of clearing after 72 hours of antibiotics**. High risk clients will need to be cleared by the Medical Director of SHC. For further information about our TB policy, please contact Infirmery staff.

Date \_\_\_\_\_

Referee \_\_\_\_\_

Signature \_\_\_\_\_