

ARC Program Referral Form

USE BLACK INK ONLY

Date: \_\_\_\_\_

Date Received: \_\_\_\_\_

(Completed by ARC Staff)

ARC PROGRAM REFERRAL FORM<sup>1</sup>

CLIENT INFORMATION

Client Name: \_\_\_\_\_  
LAST NAME FIRST NAME (Preferred Name)

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_  
YYYY/MM/DD

OHIP#: \_\_\_\_\_ VC: \_\_\_\_\_ Other: \_\_\_\_\_

Medication coverage: \_\_\_\_\_

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

Gender:  M  F  Trans  Non-binary  Other: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_

Client Contact #: \_\_\_\_\_

Current living situation: (please check the appropriate box)

- Homeless- (Couch Surf)
- Homeless- (Rough)
- Homeless- (shelter)
- Housed
- Supportive Housing

If Housed, Address: \_\_\_\_\_

REASON FOR REFERRAL:

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

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

SOURCE OF REFERRAL

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

Contact: \_\_\_\_\_ ext. \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

(please check the appropriate box)

- COMMUNITY AGENCY: \_\_\_\_\_
- HOSPITAL: \_\_\_\_\_ DEPT: \_\_\_\_\_
- SHERBOURNE HEALTH CENTRE PROGRAM: \_\_\_\_\_
- SELF

<sup>1</sup> Revised May 2017

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\*Expected Outcome/Change &/or Improvement From Short-Term Stay:

Four horizontal lines for writing the expected outcome.

Past Medical History: \_\_\_\_\_

Mental Health Issues: \_\_\_\_\_

**SUBSTANCE USE**

- Abstinence
- Actively Using Substance(s)
- Currently Detoxing
- History of Use: \_\_\_\_\_
- None

Substance(s) of choice: \_\_\_\_\_

Pattern of use: \_\_\_\_\_

Primary Care provider: \_\_\_\_\_ Contact: \_\_\_\_\_

Does the client require a service animal? Yes/No \*Client may be asked to provide third party certification for service animal, or a Regulated Health Professional’s letter confirming that the animal is required for reasons relating to disability)

**CCAC SUPPORT**

Does the client require CCAC support in the community? (please circle) Yes No

If yes,

- CCAC referral made

Date of referral: \_\_\_\_\_

Service start date: \_\_\_\_\_

Coordinator: \_\_\_\_\_ Contact: \_\_\_\_\_ ext. \_\_\_\_\_

**Reason for service:**

- Occupational Therapist
- Personal Support Worker
- Physiotherapist
- RN, Specify Service

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## **MEDICAL DEVICES**

- Cast
- Catheter
- Drains (Specify Type): \_\_\_\_\_
- Dressings (Specify Type): \_\_\_\_\_
- Ostomy
- PICC line
- Port-O-Cath
- Other: \_\_\_\_\_

## **MOBILITY AIDS**

- Cane
- Crutches
- Scooter
- Walker
- Wheelchair
- Other: \_\_\_\_\_

## **SAFETY RISKS**

- Aggression Verbal/Physical
  - Choking
  - Cognitive Impairment
  - Falls
  - Seizures
  - Self Harm
  - Suicidal Ideations
  - Other: \_\_\_\_\_
  - Behaviours of Concern: \_\_\_\_\_
- 

## **I confirm I have attached:**

- Current Med List
- Relevant consult notes (i.e. medical/surgical/Psych, Social Work, PT/OT, Wound care, etc.)
- Relevant Labs, Imaging and screening results (CXR, etc.)
- MRSA/VRE screening results (if available)
- Opiate Substitute Therapy (Methadone) Provider Information or  N/A
- Discharge Summary
- List of follow up appointments (including name of person/service; location; date; time)

Yes  No Client is aware of this referral to the **ARC** Program

Yes  No Client has participated in developing of the goals for a short term stay in the **ARC Program**

Yes  No Client has given verbal and/or written consent

333 Sherbourne Street, 3rd Floor, Toronto, ON M5A 2S5  
P: 416-324-4108 F: 416-324-4258

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- Yes  No **Client is aware that ARC Program is an environment that welcomes all people, without judgment of lifestyle, sexual orientation, belief system, race, gender or class. Diversity is embraced with respect and compassion, and discrimination towards others is not tolerated and may result in discharge from the program.**

## For Post Transition-Related Surgery Referral Only

- Client will bring supplies needed for post-operative care**  
 **Client living arrangement able to accommodate continuation of post-operative care after inpatient stay at ARC**  
**If no, please describe limitations**

- Client may need assistance in the community after their stay at ARC**  
**If yes, please specify:**

Referee Signature

Date