ARC Program Referral Form

USE BLACK INK ONLY

Date: ____________________ **Date Received:** ____________________
(Completed by ARC Staff)

ARC PROGRAM REFERRAL FORM[1]

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:** _________________________

1 Revised June 2020

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☐ **SELF**

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

____

____

____

____

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)

LHIN SUPPORT

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

If yes,

☐ **LHIN referral made**

Date of referral:___________________________

Service start date: _________________________

Coordinator:_______________________**Contact:**_________________**ext.**________

Reason for service:

☐ Occupational Therapist
☐ Personal Support Worker

- ☐ Physiotherapist
- ☐ RN, Specify Service

MEDICAL DEVICES

- ☐ Cast
- ☐ Catheter
- ☐ CPAP
- ☐ 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

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☐**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

☐**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

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☐ **Client may need assistance in the community after their stay at ARC**

If yes, please specify:

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______________________ ______________________

Referee Signature Date