ARC Program Referral Form

(USE BLACK INK ONLY – Incomplete Referrals Will Not Be Processed)

Date: ____________________

ARC PROGRAM REFERRAL FORM

CONSENT

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

□Yes □No Client has participated in developing 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, disability, sexual orientation, belief system, race, gender or class. Diversity is embraced with respect and compassion. Discrimination towards others is not tolerated and may result in discharge from the program.**

CLIENT INFORMATION

Client Name: ____

LAST NAME FIRST NAME (OPTIONAL: PREFERRED NAME)

DOB: ____________________________ **Age:** _______________

OHIP: ____________________________ **VC**: ______ **Other:** ___________________________________

Medication coverage: _____________________________

Source(s) of Income, if none put N/A: ________________________

Gender(s) (select all that apply):
□Man □Woman □Trans □Two Spirit □Non-binary □Other: ____________

Pronouns (select all that apply): □She/Her □He/Him □They/Them □Other: ____________

Client Contact Phone Number: _____________________________

Alternate Contact Name and Number: ____
Please note: We usually do not contact the client directly. Please provide an alternate contact.

Special considerations (third-party insurance, accessibility, barriers, tips for care delivery):

Current living situation (select all that apply, options continue page 2):

☐ Homeless (Couch Surf)
☐ Homeless (Rough)
☐ Homeless (Shelter)
☐ Housed

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☐ Supportive Housing

If Housed, Address: ____

Does the client require a service animal? □Yes □No
Client may be asked to provide third party certification for service animal, or a letter signed by a Regulated Health Professional confirming that the animal is required for reasons relating to disability.

LHIN SUPPORT

Does the client require home and community care services? □Yes □No
Please note ARC does not have PSW, specialized nursing services, OT or PT.

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 ______________________
☐ Port-O-Cath
☐ PICC line
☐ Other: ______________________

MOBILITY AIDS

☐ Cane
☐ Crutches
☐ Scooter
☐ Walker
☐ Wheelchair

☐ Other: ____________________________________

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SAFETY RISKS

☐Aggression, Verbal/Physical
☐Choking
☐Cognitive Impairment
☐Falls
☐Seizures
☐Self-harm
☐Suicidal Ideations

☐Other:

☐Behaviours of Concern**:**

REFERRAL

Referee Name: ___________________________________ Title: ______________________________

Contact: ________________________ ext. _______ Pager/Cell: ______________________________

Source for referral

☐ Community agency:_______________________________________

☐ Hospital: __________________________ Dept:_________________

☐ Sherbourne Health Program: ____________________

☐ Self
☐ Referring provider is **NOT** primary care provider

Reason for referral: ___________________________________ Urgency: □Routine □Urgent

Concern(s)/Indication(s)
Please note: the indications listed below are the only acceptable indications for a referral to the ARC program. If the patient's concern is not listed here, connect with ARC prior to submitting the referral.

☐ Transition-Related Surgery post-operative care

☐ Acute post-operative support

☐ Wound care

☐ Recovery from an acute episode of a chronic issue

☐ Recovery from an acute illness

☐ Medication start or titration

☐ Colonoscopy / Endoscopy preparation support

☐ Chemotherapy / Radiation symptom support

☐ IV-Antibiotics / Post-infection care

Name of suspected diagnosis/problem triggering referral: ____________________________________

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Brief Description of History, Management, and Investigations:

Expected outcome, change and/or improvement from ARC stay:

Past medical history:

Mental health concerns:

SUBSTANCE USE

☐ Abstinence
☐ Actively Using Substance(s)
☐ Currently Detoxing
☐ History of Use: ____
☐ None

Substance(s) of choice: ____

Pattern of use: ____

Current Medications:

Current Concerns: ____

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Allergies:

I confirm I have attached the following supporting documentation (*select all that apply):*

- ☐ 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)
- ☐ Personal health information that is medically relevant has not been disclosed at the request of the client

Referee Signature	Date

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