P.A.T.H. – (Priority Assistance to Transition Home)

REFERRAL FORM – COVID-19 – Service Delivery

2 pages required

Hub Area:

□ East & West Parry Sound
X North Bay □ Sault Ste. Marie
□ Sudbury □ Timmins

To be completed 1-2 business days in advance of discharge once the patient has indicated that he/she would like to use the service. (exemption for ED patients)

Fax: 705.495.7824 Phone: 705.474.8600 x3889
ATT: Michelle Meunier

Attach client info sticker (Name,DOB, Address,Phone#, Health Card#)

Expected Date and Time of Discharge: _____ **Discharge Unit & Room #**_____
Discharge Planner Name & Contact #: Please contact the Ward Clerk 705-647-1088 x2429 to provide time of pickup as writer
(Tania Osborne Social Work x2425)will not be available by phone. Thank you

"Select all that apply"

- ☐ Client is COVID-19 negative
- ☐ Client is COVID-19 Probable
- ☐ Client is COVID-19 Positive
- ☐ Client is awaiting COVID-19 testing results
- ☐ Client is not tested

Sudbury Hub	North Bay Hub	East & Parry Sound Hub	Sault Ste.Marie Hub	Timmins Hub
□ ERHHC– Espanola	□ EDH- Englehart	□ MAHC- Huntsville	□ BRDHC– Blind River	□ AGH– Iroquois Falls
□ HSN- Sudbury	□ KDH– Kirkland Lake	□ WPSCH– Parry Sound	□ HCH- Horne Payne	□ BMH- Matheson
□ MHC– Mindemoya	□ MGH- Mattawa		□ LDHC- Wawa	□ TADH- Timmins
□ MHC– Little Current	□ NBRHC– North Bay		□ SAH- Sault Ste. Marie	□ SH– Kapuskasing
□ SJGH– Elliot Lake	☒ TS– Temiskaming		□ MMH-Richards Landing	□ SRFH– Smooth Rock Falls
	□ WNGH– West Nipissing		□ TSH- Thessalon	□ SSCHS- Chapleau
				□ LMH- Cochrane
				□ NDH- Hearst

Please circle:
Number of Admissions (last 6 mths) 0-3 4-6 7-9 10+ Number of visits to ED (last 6 mths) 0-3 4-6 7-9 10+

If destination is other than the address listed in the client information, please enter the information here:

Client Lives:
□ In own home □ Apartment/Townhouse □ Alone □ Family/Caregiver
□ Family Contact Name: _____ Contact Number: _____

Transitional Information:
□ Yes □ No - Does patient have keys to their home?
□ Yes □ No - Does patient have money for groceries, supplies, laundry if required?
□ Yes □ No - Does patient require clothing?
□ Yes □ No - Pets in home? _____
□ Yes □ No - Smoking in home?
□ Yes □ No - Stairs at entrance?
□ Yes □ No - Stairs/Driveway cleared of snow?
Language(s) spoken: English / French / Other:_____

Medical Information – Known Conditions:
□ Allergies (food, medication, other): □ No □ Yes specify:_____
□ Arthritis
□ Cardiovascular
□ Cognitive Status / Mental Health Concerns
□ Isolation Precautions:□ No □ Yes specify:_____
□ Diabetes
□ Infection
□ Renal
□ Other: _____

Aids: What are the patient requirement aid(s)?
□ Bariatric Wheelchair □ Cane □ Crutches □ Independent □ Unable to climb stairs □ Walker □ Wheelchair
Oxygen: □ Patient requires 0^2 in the Home? □ Patient has portable 0^2 tank with them?

PATH Services Required (check all that apply)

□ **Settling in (maximum 2 hours may include light housekeeping, meal prep and laundry)**

□ **Medication Pick Up:** □ **Yes** □ **No - Prescription provided to patient?**

□ **Yes** □ **No - Prescription forwarded to pharmacy? Name of Pharmacy:_____**

□ **Meals __frozen meal (MOW entree, soup, dessert) Special Diet:_____**

□ **Emergency groceries**

□ **Follow-up visits**

□ **Additional support to attend follow-up medical visits**

□ **Transportation required**

□ **Wheelchair vehicle required :** □ **Able to transfer independently** □ **Unable to transfer independently**

Person(s) to assist with transfer: _____

Please provide any additional information or instructions needed the day of discharge that would assist the PATH worker to settle in the client:

LHIN Community client information:

Pre-admission client of the LHIN Home and Community Care? □ **Yes** □ **No**

New client of LHIN Home and Community Care? □ **Yes** □ **No**

LHIN Services: _____

Start Date: _____

Care Coordinator Name & Telephone #: _____

Community Support Services:

Name of Agency & Telephone #: _____

Services Requested : _____

Start Date: _____