

OSCR SHORT STAY RESPITE BEDS REFERRAL FORM

Referral Source Information			
Referral Source's first name:		Referral Source's last name:	
Referral Source's organization/agency:		Referral Source's phone #:	ext.
Date of referral: (dd/mm/yyyy)		Consent for referral obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly summarize why short stay is needed:			
Approximately, when is service needed?		<input type="checkbox"/> Within one month <input type="checkbox"/> Within the year <input type="checkbox"/> Specific date: 	

Care Recipient Information			
Care Recipient's first name:		Care Recipient's last name:	
Care Recipient's date of birth: (dd/mm/yyyy)		Care Recipient's address:	
Care Recipient's gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Care Recipient's HCN:	
Does the Care Recipient require translation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which language?	
Does the Care Recipient have an infectious disease(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of infectious condition & precautions required:	
Does the Care Recipient require Nursing for diabetes management?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the Care Recipient require Nursing for wound care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a recent O.T. assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment attached? Assessment on IAR?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List the medical conditions / diagnosis of Care Recipient:		Allergies (diagnosed or sensitivities):	
Mobility Equipment or Devices Used:		List any behavioural issues present:	

Care Recipient Assessment Information (for referrals from LHIN only)						
Date of care recipient's most recent RAI assessment (if applicable): (dd/mm/yy)		Assessment conducted by: (name of organization)				
Consent given to share assessment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment attached? Assessment on IAR?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
Type of RAI Assessment	<input type="checkbox"/> inter RAI CHA <input type="checkbox"/> inter RAI-HC <input type="checkbox"/> RAI-PC					
Please include RAI Scores below clearly						
RAI SCORES:	ADL:		IADL:		CPS:	
	MAPLE:		CHESS:		DRS:	

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Primary Caregiver Information			
Caregiver's first name:		Caregiver's last name:	
Relationship to Care Recipient:		Caregiver's home phone #:	
Caregiver's address:		Caregiver's alternate phone #:	<input type="checkbox"/> Cell: <input type="checkbox"/> Work:
Does the Caregiver require translation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which language?	
Short Stay Eligibility Criteria	Yes	No = Excluded	If you have answered NO to any of these questions, please explain reason for referral:
Is the Care Recipient 18 or older?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the client require 24 hours supervision?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the Care Recipient agreeable to Short Stay (daily intermittent care)?	<input type="checkbox"/>	<input type="checkbox"/>	
Short Stay Exclusion Criteria	Yes = Excluded	No	If you have answered YES to any of these questions, please explain reason for referral:
Does the client pose a risk to self or others?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the client require specialized behavioural care or mental health support (physically combative, verbally abusive etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
Notes:			

Fax: (905) 337-0770 or Phone: (905) 281-4443

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Direct Email: info@centralregistry.ca