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?**	☐ Yes ☐ No
Briefly summarize why short stay is needed:			
Approximately, when is service needed?	☐ Within one month ☐ Within the year ☐ 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:	☐ Male ☐ Female	**Care Recipient's HCN:**	
Does the Care Recipient require translation?	☐ Yes ☐ No	**If yes, which language?**	
Does the Care Recipient have an infectious disease(s)?	☐ Yes ☐ No	**If yes, type of infectious condition & precautions required:**	
Does the Care Recipient require Nursing for diabetes management?	☐ Yes ☐ No	**Does the Care Recipient require Nursing for wound care?**	☐ Yes ☐ No
Is there a recent O.T. assessment?	☐ Yes ☐ No	**Assessment attached? Assessment on IAR?**	☐ Yes ☐ 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:	☐ Yes ☐ No	**Assessment attached? Assessment on IAR?**	☐ Yes ☐ No ☐ Yes ☐ No
Type of RAI Assessment	☐ inter RAI CHA ☐ inter RAI-HC ☐ 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 #:**	☐ Cell: ☐ Work:
Does the Caregiver require translation?	☐ Yes ☐ 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?	☐	☐	
Does the client require 24 hours supervision?	☐	☐	
Is the Care Recipient agreeable to Short Stay (daily intermittent care)?	☐	☐	
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?	☐	☐	
Does the client require specialized behavioural care or mental health support (physically combative, verbally abusive etc.)**?**	☐	☐	

Notes:

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

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Direct Email: info@centralregistry.ca