TRANSFER FROM ACUTE CARE TO LONG-TERM CARE (LTC) CHECKLIST

Seniors, Community and Complex Care

Form ID: NUXX106305C Rev: August 2023

Patient information

THIS CHECKLIST IS REQUIRED FOR INITIAL PLACEMENTS OF ACUTE CARE PATIENTS TO LTC	
ITEM	**INFORMATION**
Primary contact – nursing unit	Name and phone number (ext): ______
Primary contact – home health	Name and phone number (ext): ______
Patient or Substitute decision maker contact	Name and phone number (ext): ______
Family Physician (if applicable)	Name and phone number (ext): ______
Is the patient medically stable? *(If no, please do not refer to LTC until stable)*	□ YES □ NO
Has a complete referral submitted?	□ YES □ NO
Has iTracker been updated?	□ YES □ NO
Infection control status: □ MRSA □ CPO □ CDI □ COVID □ N/A □ Other: ______	Infection Control Test: □ YES □ N/A Type of test: ______ Reason for test: □ Exposure □ Symptomatic Result: □ Positive □ Negative □ Pending

TO BE FAXED UPON SUBMISSION OF REFERRAL (FAX: 604-519-8550)

- □ Nursing assessment *(including skin integrity assessment)* x 1 week
- □ Physician notes x 1 week
- □ Occupational therapy/ Physiotherapy notes x 1 week
- □ Specialist consults *(including geripsych, surgery and all others)* x 1 week
- □ Social worker notes x 2 weeks *(do NOT share AGA notes or third party information)*
  Name of social worker & contact information: ______
- □ Wound care clinician consultation
- □ Hemodialysis plan:
  - Transportation & schedule details: ______
- □ Speech Language Pathology Notes:
  - Dysphagia and swallowing reports
  - Diet texture: ______
  - Mode of communication: ______
- □ Medication Administration Records x 1 week *(include PRNs and any hazardous medications such as cytotoxic)*
- □ Advanced Care Planning Records:
  - Medical Orders for Scope of Treatment (MOST) form *(ADDI105016D)*
  - Advanced Care Planning (ACP) Record *(ADDI101231H)*
  - Identification of Substitute Decision Maker(s) *(ADDI106819B)*
- □ The client has been certified under the Mental Health Act *(If yes, please send the forms as noted below)*:
  - Form 4 x 2 – Medical Certificate Involuntary Admissions *(MHXX107642)*
  - Form 5 – Consent for Treatment *(MHXX107643)*
  - Form 13 – Notification to Involuntary Patient of Rights *(MHXX100404)*
  - Form 6 – Medical Report on Involuntary Patient Renewal *(MHXX100396)*
- □ The client has behavioral concerns noted *(if yes, please send the documents as noted below)*:
  - Sleep logs x 2 weeks
  - Behavior logs x 2 weeks
  - Comprehensive care plan notes x2 weeks
  - Restraint use details x 1 week
    - Bed rails
    - Chemical restraint
    - Physical restraint
    - 1 to 1 in place

Date Faxed:	**Sent by (please print):**

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TO BE SENT UPON NOTIFICATION OF A BED MATCH FAX TO IDENTIFIED LONG TERM CARE COMMUNITY	TO BE SENT UPON NOTIFICATION OF A BED OFFER FAX TO IDENTIFIED LONG TERM CARE COMMUNITY
□ Power of Attorney *(obtain copy from Home Health)*	□ Discharge summary *(updated)*
□ Representation Agreement *(obtain a copy from Home Health)*	□ Discharge prescription
□ Discharge summary	□ If requested, Verbal MRP to MRP handover: Acute MRP Contact:_______________
□ Lab test results x 1 week	□ Consents *(Follow local acute process when obtaining consent):* ○ Care Facility Admission Consent *(HLTH 3912)* ○ Incapability Assessment Report *(HLTH 3910)*
□ Nursing assessments x 1 week	□ Client is certified under the Mental Health Act: ○ Form 20 - Leave Authorization form *(MHX100410)*
COMPLETE IF MATCHED TO BSTN UNIT	□ Nursing notes (since last sent)
□ Have restraints been used in the last week? ○ Physical ○ Chemical restraints ○ Bed rails □ Does patient have 1-on-1 supervision in hospital? □ Sleep logs x 2 weeks □ Behavior logs x 2 weeks □ Comprehensive care plan x 2 weeks	□ Transportation *(coordinate with receiving site as appropriate):* ○ Type of transportation: _______________ ○ Date and time of pick up:_______________ ○ Patient / SDM has been notified of transfer □ Upcoming appointment(s): Transportation details: _______________
ADDITIONAL PATIENT DETAILS	**ADDITIONAL PATIENT DETAILS**
□ Patient has a feeding tube: ○ Insertion date: _______________	□ Last PEG change – date: _______________
□ Patient has a urinary catheter: ○ Insertion date: _______________	□ Last urinary catheter change – date:_______________
□ Patient has a colostomy	□ Last ostomy change or LBM – date: _______________
□ Patient has a tracheostomy: ○ Date of tracheostomy change: _______________	□ Last wound/dressing change – date: _______________
□ Patient is on CPAP/BiPAP: ○ Unit has confirmed that patient/family will provide □ Patient is on O2 therapy – Mode: _______________ □ Patient requires Continuous Ambulatory Peritoneal Dialysis *(CAPD)*	□ Patient personal belongings *(to be sent with patient):* ○ Glasses ○ Dentures ○ Hearing Aids ○ Others: _______________
PATIENT EQUIPMENT NEEDS	
□ Patient uses a walker ○ Unit has confirmed that patient/family will provide	
□ Patient requires a specialty wheelchair *(type)*:___________ ○ If wheelchair is bariatric? Length: __________ Width: __________ ○ Unit has confirmed that patient/family will provide	
□ Patient requires a commode: ○ If wheelchair is bariatric? Length: __________ Width: __________ ○ Unit has confirmed that patient / family will provide	
□ Patient requires a specialty mattress: ○ Length:__________ Width: __________ ○ Unit has confirmed that patient / family will provide	
□ Patient requires a lift ○ Minimal viable type required :_______________	
□ Patient requires a transfer sling ○ Size required: _______________	
□ Patient requires other equipment *(please specify)*: __________ ○ Unit has confirmed that patient / family will provide	

Date faxed:	Sent by (please print):	Date faxed:	Sent by (please print):