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TRANSFER FROM ACUTE TO ALTERNATE LEVEL OF CARE (ALC) – LONG-TERM CARE (LTC) CHECKLIST

REGIONAL ACCESS & FLOW

THIS CHECKLIST IS REQUIRED FOR LONG TERM CARE (LTC) ALTERNATE LEVEL OF CARE (ALC) PATIENTS

ITEM	INFORMATION (FILL IN AS REQUIRED)
Service start date	
ALC designation	☐ ALC-HH ☐ EAR-RH ☐ ALC-CV ☐ ALC-LTC ☐ ALC-AGA
Referred program (only one referral per patient)	☐ PATH ☐ REHAB ☐ CV ☐ LTC
Unit contact in acute care (For Information About the Patient)	Name: _____ Phone Number and Extension: _____
Home health contact person in acute care (if applicable)	Name: _____ Phone Number and Extension: _____
Primary patient/family contact or responsible person	Name: _____ Phone Number: _____

STOP: THIS CHECKLIST (PART 1) MUST BE COMPLETED PRIOR TO SUBMITTING AN ALC REFERRAL

PART 1 – DETERMINE ELIGIBILITY AND READINESS

COMPLETE THE FOLLOWING	COMMENTS/NOTES	YES	NO
Patient designated as medically stable and does not require the intensity of services provided in the acute care setting	*If no, please do not submit referral*		
Based on interdisciplinary team rounds, patient care needs, and program criteria, the patient is appropriate and assigned ALC designation	Meditech updated: ☐ YES ☐ NO iTracker updated: ☐ YES ☐ NO		
Complete referral for Rehab, CV, PATH, or LTC ensuring all supporting documentation reflect patient status and meet program criteria	All supporting documentation reflects patient status: ☐ YES ☐ NO Interdisciplinary Care Conference Conducted: ☐ YES ☐ NO Date:_____		
Patient or SDM aware of and consented to ALC designation and potential move to appropriate ALC bed within FHA, not a specific site, with anticipated discharge date			
Patient or SDM aware of cost of ALC bed. *CV daily rate is $40.68/day effective January* 2022			
All tests/consults are completed or booked as outpatient (Upcoming Scheduled Appointments)			
Recent lab work - within 7 days			
Infection control status	Reason for test: ☐ Exposure ☐ Symptomatic Type of test: _____Date of last test: _____ Result: ☐ Positive ☐ Negative		
Medical Orders for Scope of Treatment (MOST) form (ADDI105016) complete	*This must be appropriate for the ALC destination*		
Discharge summary available in Meditech within the last 7 days			
Are there any Adult Guardianship Act (AGA) concerns that may need follow up? If so, who is the contact for information handover? Designation to stay as ALC-AGA until resolved	Contact for AGA handover: Telephone: (___)____ - _____ ext. _____ Email:		

TURN PAGE OVER FOR PART TWO

Legend:
EAR-RH: Eligibility Assessment Required-Rehab
AGA: Adult Guardianship Act
CV: Convalescent
HH: Home Health
PATH: Patient Assessment and Transition Home
SDM: Substitute Decision Maker

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PART 2 – COMPLETE UPON BED MATCH FROM ALC REPORT IN STRATA PATHWAYS		
DOCUMENTS TO BE SENT TO MATCHED CARE HOME WITHIN 48 HOURS (ALL DOCUMENTS WITH A "*" ARE MANDATORY)	**COMMENTS/NOTES**	**DATE FAXED**
Current MAR* (including PRN medications) and any medication related records*	*Please include any hazardous drugs (including cytotoxic medication)*	
Medical Orders for Scope of Treatment (MOST) form (ADDI105016)*, Advanced Care Planning Record (ADDI101231), Identification of Substitute Decision Maker (ADDI106819)	*Review the MOST as per the current stay*	
Recent lab work and test results*		
All specialist consults/referrals*		
Wound care records/head-to-toe skin integrity assessment*		
Two weeks of social work (SW) notes and/or most recent SW assessment*	*Do NOT share AGA notes or third party personal information*	
If significant SW related concerns, contact of relevant clinician*		
Diet (dysphagia/swallowing reports, diet texture)*		
Restraint use within last week (if applicable, types)*	*Restraint use is limited in long-term care*	
1 week most recent nursing, physician, OT/PT, RD notes*		
Hemodialysis plan (transportation and schedule), if applicable*		
Language or communication concerns (SLP Notes)		
If applicable (ex. Behavioural Support Transition Neighbourhood) 2 weeks of sleep log, behavioural log, nursing notes and, comprehensive care plan		

PART 3 - COMPLETE UPON BED OFFER (FOLLOW UP WITH ACCESS, CARE, AND TRANSITIONS COORDINATOR IF NO BED OFFER IS RECEIVED WITHIN 48 HOURS OF THE MATCH)						
EQUIPMENT FOR FACILITY TO CONSIDER IF NOT ALREADY INDICATED IN RAI	Patient to provide ✓	Receiving site to provide ✓	N/A ✓	**Additional Comments (size, type, etc)**	**RECEIVING SITE AWARE YES**	**NO**
Feeding Tube						
Urinary catheter bag						
Colostomy						
Tracheostomy						
Oxygen				**home oxygen organized by acute*		
CPAP/BiPAP		*N/A*		**patient should provide machine*		
Continuous Ambulatory Peritoneal Dialysis (CAPD)						
Specialty wheelchair (indicate size if Bariatric)		*N/A*		**patient needs to provide specialty wheelchair in consultation with OT*		
Walker						
Lift (indicate minimal viable type)	*N/A*					
Transfer sling (indicate size)	*N/A*					
Commode (indicate size if Bariatric)	*N/A*					
Specialty mattress (indicate size if Bariatric)						
Other (Please indicate):						

If any piece of equipment is a barrier to transfer, LTC sites are requested to reach out to the acute care site or the Access Coordinator to request support or clarification.

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PART 4 – COMPLETE ONCE DISCHARGE DATE IS DETERMINED		
COMPLETE THE FOLLOWING PRIOR TO TRANSFER TO FACILITY (ALL DOCUMENTS WITH A "*" ARE MANDATORY)	**COMMENTS/NOTES**	**DATE FAXED**
Transportation: coordinate with receiving site as appropriate*	Type of Transportation: Date and Time of Pick Up:	
Patient/SDM notified of transfer*	☐ Yes ☐ No Method of Communication: _____ Date notified: _____ Follow up Required? ☐ Yes ☐ No	
Care Facility Admission Consent (HLTH 3912) and Incapability Assessment Report (HLTH 3910)		
COVID-19 swab date and results (if applicable, as per COVID-19 transfer algorithm)		
Verbal MRP to MRP handover, if requested	Requested? ☐ Yes ☐ No; LTC MRP Contact: _____	
Power of Attorney/Representation Agreement		
Form 20 (Mental Health Act) Leave Authorization form (MHX100410) if client is certified*		
Upcoming appointment(s) details (post-discharge, if applicable and include a plan for transportation)*		
PART 5 – COMPLETE PRIOR TO TRANSFERRING PATIENT		
CHECK AND COMPLETE THE FOLLOWING PRIOR TO TRANSFER TO RECEIVING SITE (ALL DOCUMENTS WITH A "*" ARE MANDATORY)	**COMMENTS/NOTES**	**DATE FAXED**
Discharge medication reconciliation and orders by Physician or Nurse Practitioner*		
PharmaCare Special Authority Request form, if applicable* (MRXX104406, HLTH 5328)		
Updated discharge summary*		
Bowel records*		
Nurses notes		
Date of last urinary catheter change*	☐ Not Applicable ☐ Applicable – Date:	
Date of last ostomy change*	☐ Not Applicable ☐ Applicable – Date:	
Date of last PEG change*	☐ Not Applicable ☐ Applicable – Date:	
Date of last wound/dressing change*	☐ Not Applicable ☐ Applicable – Date:	
PERSONAL BELONGINGS SENT WITH PATIENT	**COMMENTS/NOTES**	**DATE FAXED**
Glasses	☐ Not Applicable ☐ Applicable	
Walker	☐ Not Applicable ☐ Applicable	
Wheelchair	☐ Not Applicable ☐ Applicable	
Dentures	☐ Not Applicable ☐ Applicable	
Hearing aids	☐ Not Applicable ☐ Applicable	
Other:		
NOTES		
PLEASE FAX COMPLETED TRANSFER CHECKLIST TO RECEIVING SITE OR SEND WITH PATIENT		