fraserhealth

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

REGIONAL

Directions: This document is required to be completed by acute units for acute care patients transitioning to LTC, as their initial placements.

Patient care coordinator (PCC) or Care management coordinator (CMC)	Name: _____ Phone number (extension): _____
Primary contact for home health	Name and Role: _____ Phone number (extension): _____
Patient or substitute decision maker (SDM) contact	Name and Relationship: _____ Phone number (extension): _____
Family Physician *(If applicable)*	Name and phone number (extension): _____
Is the patient requiring the intensity of services provided in the acute care setting?	☐ Yes ☐ No; *if yes, do not refer and cancel referral to LTC until stable*
Does patient have an ALC-LTC designation?	☐ Yes ☐ No; *if no, update service designation in Meditech*
Has a complete referral already been submitted? *(Confirm with home health)*	☐ Yes ☐ No; *if no, do not proceed with sending identified information below*
Infection control status: ☐ N/A ☐ MRSA ☐ CPO ☐ COVID-19 ☐ Clostridioides difficile Infection (CDI) ☐ Other: _____	Infection Control Test: ☐ YES ☐ N/A Date Completed: _____ Type of test: _____ Reason for test: ☐ Exposure ☐ Symptomatic Result: ☐ Positive ☐ Negative ☐ Pending

A. This page and items below are to be faxed to 604-519-8550 within 24 hours of referral. All documents below are mandatory. Mark each item appropriately (✓ = Yes and x = N/A)

☐ Nursing assessment and notes *(including skin integrity assessment and wound care plan)* - 1 week

☐ Most responsible practitioner (MRP) (Physician/Nurse Practitioner) notes (*please include History & Physical)* - 1 week

☐ Occupational therapy, Physiotherapy notes - 1 week

☐ Specialist consults *(including geripsych, surgery, wound care clinician and all others)* - all consult reports during inpatient stay

☐ Medication Administration Records (MARs) and associated medication documentation forms - 1 week
(Include PRNs and any hazardous medications such as cytotoxic medications)

☐ Social Worker notes *(do NOT share Adult Guardianship Act (AGA) notes or third party information)* - 2 weeks

☐ Patient is receiving hemodialysis treatment. If yes please specify:
- Frequency: _____
- Location and contact number: _____

☐ Speech Language Pathology (SLP) and Dietitian notes - 1 week
- Dysphagia and swallowing reports

☐ Advanced Care Planning Records:
- Medical Orders for Scope of Treatment (MOST) *(ADD1105016D)*
- Advanced Care Planning (ACP) Record *(ADD1101231H)*
- Identification of Substitute Decision Maker(s) *(ADD11106819B)*

☐ Patient is currently certified under the Mental Health Act. If yes, please send the following:
- Form 4.1 and 4.2 - Medical Certificate Involuntary Admissions
- Form 5 - Consent for Treatment *(MHXX107643)*
- Form 13 - Notification to Involuntary Patient of Rights *(MHXX100404)*
- Form 6 - Medical Report on Involuntary Patient Renewal *(MHXX100396)*

☐ Patient has behavioral concerns noted. If yes, please send the following:
- Sleep logs - 2 weeks
- Behavior logs - 2 weeks
- Comprehensive care plan notes - 2 weeks

☐ Does the patient have constant care in place (e.g. 1 to 1 supervision or security)?

☐ Have restraints been used in the last week? If yes, please specify: ☐ Chemical restraint ☐ Physical restraint

Date Faxed (dd/mm/yyyy):	Time:	Sent by (please print):	Designation:

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B. The items below are to be faxed within 48 hours to the identified LTC community upon a bed match. All documents below are mandatory. Mark each item appropriately (✓ = Yes and x = N/A).

The LTC community the patient is matched to: Status in Strata Pathway "Pending" / "Pending Accepted".	**Location:** _____ **Fax Number:** _____
☐ Power of attorney *(obtain a copy of the document from home health)*	**Complete items below if patient matched to a Behaviour Stabilization Transition Neighbourhood (BSTN):**
☐ Representation agreement *(obtain a copy of the document from home health)*	
☐ Discharge summary	☐ Have restraints been used in the last week? If yes, specify: ☐ Physical ☐ Chemical restraints
☐ Lab test results - 1 week	
☐ Nursing assessment and notes - 1 week	☐ Does client have constant care in place (e.g. 1 to 1 supervision or security?
Complete patient equipment needs below: (Bariatric: estimated body weight greater than 350 lbs)	☐ 2 weeks of notes (send the following): ☐ Sleep logs ☐ Behaviour logs ☐ Comprehensive care plan
☐ Patient uses a mobility aide *(unit has confirmed that patient/family will provide):* ☐ Walker ☐ Cane ☐ Power scooter	**Complete additional patient items below:**
	☐ Patient is on Oxygen therapy. If yes, please specify: • L/min and Mode: _____
☐ Patient requires a lift with a transfer sling. If yes, please specify: • Minimal lift required: _____ • Sling size required: _____	☐ Patient has a tracheostomy. If yes, please specify: • Type: _____ ☐ Cuffed ☐ Uncuffed (LTC is unable to accept cuffed Tracheostomies) • Size: _____
☐ Patient requires a specialty wheelchair. If yes, please specify *(unit has confirmed that patient/family will provide):* • Type: _____ ☐ Is this a bariatric equipment? • Length:_____ Width: _____	☐ Patient is on CPAP/BiPAP *(unit has confirmed that patient/family will provide)*
	☐ Patient has a feeding tube. If yes, please specify: • Is this new? ☐ Yes ☐ No • Insertion date: _____ • Type and Size: _____
☐ Patient requires a specialty mattress. If yes, please specify *(unit has confirmed that patient/family will provide)* • Type: _____ • Length:_____ Width:_____	☐ Patient has an ostomy. If yes, please specify: • Type: _____
	☐ Patient requires Continuous Ambulatory Peritoneal Dialysis (CAPD)
☐ Patient requires a commode *(unit has confirmed that patient/family will provide):* ☐ Is this a bariatric equipment? • Length: _____ Width:_____	☐ Patient has a urinary catheter. If yes, please specify: • Insertion date: _____ • Type/Size: _____

Date Faxed (dd/mm/yyyy):	**Time:**	**Sent by (please print):**	**Designation:**

C. The items below are to be faxed to the identified LTC community within 24 hours upon a bed offer. All documents are mandatory. Mark each item appropriately (✓ = Yes and x = N/A).

The LTC community the patient is being transferred to.	**Admission date offer:** _____ **Location:** _____ **Fax Number:** _____
☐ Discharge summary *(updated)*	**Complete additional patient details below.**
☐ Discharge prescription	☐ Last PEG change - date: _____
☐ Imaging and other investigations - 1 week	☐ Last urinary catheter change - date: _____
☐ If requested, Verbal MRP to MRP handover. Acute MRP Contact information: _____	☐ Last ostomy change or LBM - date: _____
	☐ Last wound/dressing change - date:
☐ Consents *(Follow local acute process when obtaining consent):* • Care Facility Admission Consent *(HLTH 3912)* • Incapability Assessment Report *(HLTH 3910)*	☐ Patient personal belongings. If yes, please specify (to be sent with patient): ☐ Glasses ☐ Dentures ☐ Hearing Aids ☐ Others:_____
☐ Client is certified under the Mental Health Act: • Form 20 - Leave Authorization form *(MHXX100410)*	
☐ Current nursing assessment and notes *(since last sent)*	

Date Faxed (dd/mm/yyyy):	**Time:**	**Sent by (please print):**	**Designation:**