PATH
Priority Assistance to Transition Home

East & West Parry Sound

Referral Form

Referrals are accepted 5 days per week
(Monday - Friday: 9 am - 4 pm)

Fax completed form to PATH Office: **705-746-8139**
Tel: 705-746-5102 or 1-888-746-5102

Hospital Patient Label

PATH Core Services

- Transportation Home
- Attendant Settling-In Service
- In-Home Safety Assessment
- PATH Coordinator follow-up call to client & referrals to other community services as required

Patient meets PATH Eligibility Criteria? 65+ or 55+ with exceptional circumstances, stable condition, client and/or caregiver able to direct own care, can manage with 1 person transfer

☐ Yes Exceptional circumstances _____

Patient or Substitute Decision-Maker has given verbal consent to collect, use and disclose information?

☐ Yes ☐ No

Hospital Discharge Information

Discharge Date:	**Form Completed By:**
Discharge Time:	**Title:**
Unit/Room#:	**Phone/Cell:**

Source Hospital: ☐ **HSN** (Sudbury) ☐ **NBRHC** (North Bay) ☐ **MAHC** (Huntsville) ☐ **WPHSC** (Parry Sound)

Client Information

Name: **D.O.B.**

Destination Address: **Town:**

Phone#: **Language:** ☐ **English** ☐ **Other(s):**

General Medical Condition

Main Reason for Hospitalization:

Known Conditions: ☐ Arthritis ☐ Cardiovascular ☐ Diabetes ☐ Infection ☐ Renal ☐ Other:

Cognitive Status / Mental Health Concerns:

Isolation Precautions: ☐ No ☐ Yes -Specify:

Allergies (food, medication, other): ☐ No ☐ Yes -Specify:

Mobility: ☐ Independent ☐ Unable to climb stairs ☐ Requires mobility aid: ___Cane ___ Walker
☐ Wheelchair ☐ Bariatric Wheelchair

Oxygen: ☐ Requires O^2 in the home ☐ Has portable O^2 tank with them

Family or Caregiver Contact Information (if applicable)

Name 1:	**Phone #:**	**Relationship:**
Lives with Patient? ☐ Yes ☐ No	Contacted? ☐ Yes ☐ No	Comments:
Name 2:	**Phone #:**	**Relationship:**
Lives with Patient? ☐ Yes ☐ No	Contacted? ☐ Yes ☐ No	Comments:

Environmental Factors

Lives Alone?	☐ No ☐ Yes	**Stairs at Entrance?**	☐ Yes ☐ No
Pets in home?	☐ No ☐ Yes -Describe:		
Smoker?	☐ No ☐ Yes	**Access to home will be clear?** (i.e. snow removed)	☐ Yes ☐ No

Checklist - PATH Optional Services Requested

Transportation Home	☐ Yes	☐ No	
To include senior care provider?	☐ Yes	☐ No	
Wheelchair bound, able to transfer?	☐ Yes	☐ No	
Wheelchair bound unable to transfer?	☐ Yes	☐ No	
Medication Pick Up	☐ Yes	☐ No	
Prescription Provided to Patient?	☐ Yes	☐ No	
Prescription forwarded to Pharmacy?	☐ Yes	☐ No	
Medical Supplies Pick Up	☐ Yes	☐ No	
Grocery Pick Up	☐ Yes	☐ No	
Frozen Meal (MoW)	☐ Yes	☐ No	**Special Diet:**

Comments

Client Items

Keys Available? ☐ Yes ☐ No Clothing/Shoes Available? ☐ Yes ☐ No Money Available for Items above? ☐ Yes ☐ No

CCAC Client Information

Pre-admission CCAC Client? ☐ Yes ☐ No

New CCAC Client? ☐ Yes ☐ No

Case Manager Name:

Tel:

CCAC Services: _____ Start Date: _____

Community Support Services: Name of Agency: _____ Tel: _____

Services Requested: _____ Start Date: _____

Additional Information

Please provide additional information that would assist the PATH Attendant to support the client to settle in at home.