

**REFERRAL FORM for PEOPLE EXPERIENCING HOMELESSNESS affected by COVID
TORONTO SHELTER AND COMMUNITY PROVIDERS**

Submit to Inner City Health Associates: Electronically: <https://icha.hypercare.com> OR Fax: 647-689-7263

NOTE: Submit one referral at a time or it will not work. Fill out form WITH client to help with details
For assistance with submission/faxing, page MD/RN at 289-212-6843

Please **also** GIVE a hard copy of this form to client to bring to the CAC/ED.

PART ONE: SHELTER/COMMUNITY PROVIDER TO COMPLETE AND FAX TO ICHA
(ED/CAC to complete if client self-presented)

First Name: _____ Last Name: _____ Gender: _____

Children to accompany?: Y N Names of children: _____ (each child requires own form if being referred)

Client Phone #: _____ DOB: _____ Preferred language : _____

Case manager: _____ Family MD/NP/Psych: _____ Indigenous _____ LGBTQ2S (select if known)

Service provider/shelter: _____ Service provider staff name: _____ Call-back #: _____

CAC appointment date/time (if applicable): _____ Testing location (CAC/ ER): _____

Eligibility: (check all that apply)
<input type="checkbox"/> COVID Positive – Who notified the client? _____ Where tested? _____ <input type="checkbox"/> Close Contact – Date of contact _____ Type of contact _____ <input type="checkbox"/> Symptomatic – List symptoms _____ <input type="checkbox"/> Not experiencing a medical emergency <input type="checkbox"/> Age 16+ (or with a guardian) If client is age <16 , name and relationship of legal guardian _____ <input type="checkbox"/> Patient aware and accepts transfer to CAC for testing AND to Recovery Site for full period of isolation <input type="checkbox"/> Client cannot isolate in their home shelter. Please page ICHA to discuss further if unsure.

MEDICAL CONDITIONS (e.g. Asthma):	MEDICATIONS (attach MAR or ODB record if applicable) *** Remind client to bring all medications with them
SUBSTANCES USED:	METHADONE / SUBOXONE? Select if client uses one
IN A MANAGED ALCOHOL PROGRAM? Y N	ALLERGIES:
DO SHELTER STAFF SUPPORT WITH: Eating meals Toileting Showering Thoughts of self-harm/suicide Medications Other Describe:	IS AN ACCESSIBLE ROOM REQUIRED? Y N Describe: CAN THE CLIENT TRANSFER INDEPENDENTLY FROM THEIR DEVICE TO A BED? Y N

**REFERRAL FORM for PEOPLE EXPERIENCING HOMELESSNESS affected by COVID
TORONTO SHELTER AND COMMUNITY PROVIDERS**

Fax page 2 to Inner City Health Associates: 647-689-7263 or submit through <https://icha.hypercare.com>.

Incomplete referrals will not be processed. For assistance, page MD/RN at 289-212-6843.

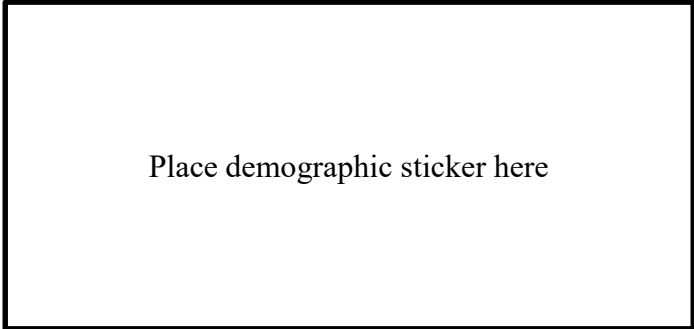
If the client self-presented, please complete page 1 as well.

PART TWO: CAC OR EMERGENCY DEPARTMENT TO COMPLETE AND FAX TO ICHA

Patient Name: _____

DOB: _____

OHIP/IFH: _____



Date/time of assessment: _____ Location of assessment: _____

Vital signs: Date _____ Time _____

O2 sat: _____ RR: _____ HR: _____ BP: _____ T: _____

Reason for acute care visit, if applicable: _____

Complete ONE of the following:

BOX A: After a clinical assessment, this client should be transferred to the Recovery Site for Isolation (all must apply).

- Had a COVID test completed, AND
- Is medically stable for an outpatient setting, AND
- Can independently complete activities of daily living, AND
- Requires isolation due to clinical concern of COVID*, close contact status, or COVID positive status
*(*Refer to: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_reference_doc_symptoms.pdf, consider atypical symptoms in infants, children, older adults and those with a developmental disability)*

BOX B: After a clinical assessment, this client SHOULD NOT be transferred to the Recovery Site for Isolation

- I **do not** have an ongoing clinical concern for COVID and do not recommend isolation
- If no isolation is required, please contact the referring site/shelter to inform
- Please ensure that this form is sent with the client back to the referring site/shelter

For both Box A and Box B, Please fax this page of the referral form to Inner City Health Associates. If transportation is already appropriately waiting for the client, no page to ICHA is required.

Referring MD/NP: _____ CPSO #: _____

Signature _____ Phone number: _____