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)

- ☐ COVID Positive – Who notified the client? _____Where tested? _____
- ☐ Close Contact – Date of contact _____ Type of contact _____
- ☐ Symptomatic – List symptoms _____
- ☐ Not experiencing a medical emergency
- ☐ Age 16+ (or with a guardian) If client is age <16 , name and relationship of legal guardian _____
- ☐ Patient aware and accepts transfer to CAC for testing AND to Recovery Site for **full period of isolation**
- ☐ 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: **IN A MANAGED ALCOHOL PROGRAM? ☐ Y ☐ N**	**☐ METHADONE / ☐ SUBOXONE? Select if client uses one** **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**

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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: _____

Place demographic sticker here

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: _____