PARKDALE QUEEN WEST Community Health Centre
www.pqwchc.org

Parkdale Queen West Community Health Centre

Improving Health Access Referral Information

PROGRAM INFORMATION:

Referral for the Health Access Program operated under Parkdale Queen West Community Health Centre. This program is open to patients being discharged, or having been recently discharged, from the hospital into community who require increased access to health services and community supports.

DESCRIPTION:

The Health Access Program is a time-limited case management focused on system navigation and care coordination program that supports newly discharged clients to transition back into the community and reduce hospital readmissions. Successful referrals will receive timely access to community supports, care coordination between new and existing services, and discharge planning once service integration has been secured.

Referrals are accepted by Hospitals, Primary Care, Home Care and Community Agencies. Intake workers will verify that referral criteria are met, including hospital admission and discharge.

ELIGIBILITY CRITERIA:

Clients Must be:

- One recent/current acute hospital admission
- A minimum of 3 admission in one year for a chronic health issue
- Be in need of services, supports or resources to live safely in the community.
- Be a resident of South Parkdale

Services Offered

- Short-term case management (approximately 3 months)
- Conducts thorough client assessments of current circle of care to determine if adequate supports are in place.
- Referral and connection to suite of holistic and clinical services to address client needs and prevent hospital admissions.
- Facilitate the development or integration of a comprehensive care team.
- Oversee care planning and care coordination.
- Accompaniments and home visits with/to clients to appointments related.
- Discharge planning into sustained wrap around care

PARKDALE QUEEN WEST Community Health Centre
www.pqwchc.org

Improving Health Access
Referral Form

Short-Term Care Coordination and Case Management Services for clients being discharged or recently discharged from hospitals into community; and clients who have a recent history of hospital admission with a risk for readmission. To be eligible, clients will also require enhanced supports and services to transfer safely back to the community.

Eligibility:

- ☐ One recent/current acute hospital admission OR
- ☐ A minimum of 3 admission in one year for a chronic health issue
- ☐ Be in need of services, supports or resources to live safely in the community
- ☐ Be a resident of South Parkdale

Client Information:

Preferred Name: First Name:
Last Name:

DOB:

Health Card: Version Code: Province:

Pronouns:

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Intersex ☐ Two-Spirit

Contact Information:

Phone Number: Email:

Address:

Unit, Street, City, Postal Code

Program Information:

Referral Source: ☐ Hospital ☐ Primary Care ☐ Community ☐ Home Care

Does your client reside in South Parkdale: ☐Yes ■No

Is your client currently in hospital: ■Yes ☐No Reason for Admission:

SUBMIT COMPLETED REFERRAL TO:
Cristina Raposo
Email: craposo@pqwchc.ca Fax : 416-537-3526
SUBJECT LINE: Health Access System Navigation

PARKDALE QUEEN WEST Community Health Centre
www.pqwchc.org

Anticipated Discharge Date:

History of Hospital Admissions in the last 6 months:

Admission Date: Reason: Discharge Date:

Current Health Conditions:

Click or tap here to enter text.

Is the client connected to case management services: ■Yes ■No
Does the client currently have a Primary Care Provider: ☐Yes ☐No
Is the Client connected to home care: ☐Yes ☐No
Does the client have family support: ☐Yes ☐No
Does the client have other social support (friends or social service agencies): ☐Yes ☐No

Presenting Concern:

Click or tap here to enter text.

Referral Contact

Primary:
Name:
Agency/Hospital:
Phone:
Email:

Secondary:
Name:
Agency/Hospital:
Phone:
Email:

If in Hospital:
Unit #:
Room #:
Bed #:

SUBMIT COMPLETED REFERRAL TO:
Cristina Raposo
Email: craposo@pqwchc.ca Fax : 416-537-3526
SUBJECT LINE: Health Access System Navigation

PARKDALE QUEEN WEST Community Health Centre
www.pqwchc.org

Consent Form
Collection, Use & Disclosure of Personal Health Information

Client Consent* to the collection, use and disclosure of Personal Health Information

Health Access Systems Navigation (HASN) is a Case Management Service attached to Parkdale Queen West Community Health Centre. To protect your privacy, HASN follows the Ontario Personal Health Information Protection Act. None of your Personal Health Information will be collected or shared with any person other than those involved in your care, except with written consent or if required by law.

I consent to collection and use of information (including diagnostic and needs assessments, reports from service providers, discharge plans) between the referring hospital / agency and HASN for the purpose of:

- Coordinating your care between HASN partners
- Assessing your needs
- Developing plans of care and matching to appropriate supports

I understand that I may withdraw my consent at any time by giving notice in writing to my HASN case manager. Once I withdraw consent, my Personal Health Information shall no longer be shared or disclosed to HASN partners.

Client Name: _____

Client signature: _____

Date (MM/DD/YY): _____

*If applicable, Substitute Decision Maker's (SDM)
Name:_____

SDM's signature: _____

Date (MM/DD/YY): _____

SUBMIT COMPLETED REFERRAL TO:
Cristina Raposo
Email: craposo@pqwchc.ca Fax : 416-537-3526
SUBJECT LINE: Health Access System Navigation

PARKDALE QUEEN WEST Community Health Centre
www.pqwchc.org

Consent Form
Release of Information

Client Consent* to the release of information by contact persons or agencies

In the referral form, you have given us the names and contact information of friends, relatives, service providers or other people who are chosen by you to be added to your circle of care and be invited to participate in your care plan along with HASN. We will be sharing information only requested and specified by the client.

I consent to the HASN partners contacting the individuals or organizations I named on the release of information consent form below. I authorize these people to release information regarding my care needs to HASN partners .

Contact Name	Relationship	Contact Information	Type of Information Shared

Client Name: _____

Client signature: _____ _____

Date (MM/DD/YY): _____

SUBMIT COMPLETED REFERRAL TO:
Cristina Raposo
Email: craposo@pqwchc.ca Fax : 416-537-3526
SUBJECT LINE: Health Access System Navigation