

Referral Form for Shelter, Support and Housing Administration's COVID-19 Recovery and Isolation Program for People Experiencing Homelessness

Fax to SSHA: 416-696-3463 with COVID-19/Monkeypox results and documents.
 Please fax one referral at a time. Incomplete referrals will not be processed.
 Please call SSHA at 437-347-9976 if you do not hear back in 30 minutes after submitting referral.

Client Demographics

Client Name:	Gender:	DOB:
OHIP/IFH #:	SMIS ID:	
Shelter Address:		
Phone Number:		
Indigenous: Yes / No / Unknown	Preferred Language:	
Vaccination Status (date of dose): 1 st dose:	2 nd dose:	
3 rd dose:	Additional doses:	

COVID-19 Information

COVID-19 positive: Yes / No
Symptomatic with results pending: Yes / No
Suspected close contact with COVID+ individuals with pending or negative results: Yes/No
Date of last contact: _____ nature of contact: _____
Date of swab: _____ Location tested: _____
Date of symptom onset: _____
Symptoms and course: _____

Monkeypox Information

Monkeypox positive confirmed: Yes / No
Symptomatic with results pending: Yes / No
Suspected close contact with MPOX positive individuals with pending or negative results: Yes / No
Date of last contact: _____
Date of swab: _____ Location tested: _____
Date of symptom onset: _____
Symptoms and course: _____

If from Hospital or CAC:

Oxygen Saturation:	Respiratory Rate:	Heart Rate:
Blood Pressure:	Temperature:	O2 therapy required:
Walking O2 sat or 1 minute sit to stand test:		

Medical Information (include attachment to provide additional information if necessary)

Medical problems: Yes / No
If yes, provide details: _____

List of medications:				
Client self-administered: Yes/No				
If no, what nursing supports are in place:				
Family Physician/Medical Practitioner:				
Home Pharmacy:	Days of supply of meds client has:			
Substances				
Does the client use substances regularly: Yes / No / Unknown				
If yes, which substances (please circle):				
Cigarettes	Alcohol	Cannabis	Stimulants	Opioids
If yes to opioids, receiving treatment: Yes / No				
select treatment:	Methadone	Suboxone	Kadian	
Supports				
Does the client have a case worker or mental health worker that they would benefit from connecting with during their stay? Yes / No				
If yes, please include name and contact number:				
Does the client need help with (select all that apply):				
Feeding	Toileting/showering			
Mobility aid	Thoughts of self-harm or suicide	Aggressive behavior	PSW	
Are there any emotional or behavioural needs that would impact the person's ability to isolate safely? Yes / No / Unknown				
If yes provide details:				
Does the client accept transfer to the Recovery and Isolation Program for the full isolation period? Yes / No				
Referral Source:				
Name:				
Organization:				
Phone Number:				

IMPORTANT: Please send client with their clothes and any other personal items for 10 days in the event client is admitted to the Isolation program.

Shelter, Support and Housing Administration collects personal information on this form under the legal authority of the Reopening Ontario (A Flexible Response to COVID-19) Act, 2020, SO 2020, Chapter 19, section 2, the City of Toronto Act, 2006, SO 2006, Chapter 11, Schedule A, section 136(c), the Housing Services Act, 2011, SO 2011, Chapter 6, Schedule 1, section 6, and the Toronto Municipal Code, Chapter 59, Emergency Management. The information is used to record information related to the health, safety and well-being of staff, client and visitors to enhance safety in the Homelessness Service Settings. Information will only be shared with Toronto Public Health when requested. Questions about this collection can be directed to the Manager, Homelessness Initiatives & Prevention Services by calling 416-392-8741.