AIA Referral Form - Guide for Completion

General Completion Guidelines

1. **One form is required for each client requiring isolation. This includes children and/or escorts attending with clients (even though the individual may not be on isolation). All minors must be accommodated with an adult.**
2. **The form can be completed on paper or in a fillable PDF version by going to the following link: https://sharedhealthmb.ca/files/aia-referral-form.pdf**
3. **For forms completed on paper, selection lists can be found in the AIA Selection Lists document on the Shared Health website. *Note: if more than one selection is required from dropdown, type selections out rather than choosing from selection list.***
4. **Email completed forms to AIAreferral@sharedhealthmb.ca *AND* call Intake Coordinator @ 204-795-3093.**

Section 1: Client Information:

- Date of referral: enter day/month/year e.g. 22/Jun/2021
- Time: enter utilizing 24-hour clock
- Client Name: enter first name, last name
- MB PHIN: enter PHIN
- Client Phone #: enter best number to reach client
- Date of Birth: enter day/month/year e.g. 22/Jun/2021
- Gender: indicate most appropriate
- MB Health: enter PHIN
- Address: indicate current address of client
- Primary Language: indicate most applicable
- English Language Level: indicate most appropriate;
  - "No Barrier" means a person speaks fluent English;
  - "Partial barrier" means a person speaks functional, but limited English and would benefit from interpretation; and
  - "Full Barrier" means a person speaks no English and requires interpretation
- Racial, Ethnic Identity: indicate the option that best describes the racial or ethnic community that the client identifies with
  - select from dropdown or refer to selection list; specify if not listed
- Treaty/N Number: indicate the registration number used to access health benefits under FNIHB Non-Insured Health Benefits program.
  - a "Treaty Number" for First Nations people is 10 digits
  - an "N Number" for Inuit is 8 digits and starts with an N
- Home Community: indicate from which community clients are currently residing
  - select from dropdown or refer to selection list; specify if not listed

Section 2: Referral Information:

- Service Delivery Organization: indicate which organization the referral is being sent from
  - select from dropdown or refer to selection list; specify if not listed
- Agency Referred from: indicate where referral is coming from e.g. Community, Hospital

- select from dropdown or refer to selection list; specify if not listed
- Referred by: indicate first and last name with designation
- Phone #: indicate phone # to reach referral source
- Referral discussed with client: indicate N/Y, including criteria and script

Section 3: COVID-19 Information:

- Vaccine Status: indicate whether client has been vaccinated, how many doses and when the last dose occurred
- MAB (Monoclonal antibody treatment): Indicate if client has already received this treatment by checking this box. *Monoclonal antibody treatment can only be given once. It is important to identify if a client has received.*
- Antiviral: Indicate if client has already received this treatment by checking this box. *There are two forms of treatment for COVID-19 being used in Manitoba: Oral Antivirals (Paxlovid) and Remdesivir.*
  Paxlovid-oral antiviral therapy for Covid-19 is prescribed to help keep high-risk patients from illness and/or hospitalization.
  Remdesivir is an intravenous medication that is used to prevent worsening of COVID-19 in adults and is expected to reduce the severity of illness and hospitalization rate for some patients by stopping the virus from multiplying in your body's cells.
- Potentially eligible for anti-viral treatment: indicate Y for treatment if client is eligible based on Antiviral criteria, these medications can be offered to unvaccinated, partially vaccinated or immunocompromised individuals who meet selection criteria (see link: https://sharedhealthmb.ca/covid19/treatment/)
- Previously tested positive for COVID-19 in the last 6 months: indicate N/Y and date, day/month/year e.g. 22/Jun/2021
- Source Case: indicate N/Y; source case is considered a positive case
- Contact: indicate N/Y; contact is considered a contact to a positive case
- Symptomatic: indicate N/Y if the client has symptoms
- Investigation number: indicate if known
- Start of symptoms date: indicate date of symptom onset
- Symptom types: include all or any symptoms presenting
  - select from dropdown; add additional symptoms if required by typing in same or refer to selection list
- Date of last exposure: indicate when client was last exposed to a positive case
- Self-isolation required until: indicate date that isolation is required and specify the time e.g. Midnight or AM
- Tested: indicate N/Y and type of test if known
- Test type: indicate rapid, PCR, etc.
- Date of test: indicate date, day/month/year e.g. 22/Jun/2021
- Test result: indicate if test results known
- Non-COVID-19 Referral: indicate if Y and specify reason for request

Section 4: Reason for Referral/Housing Status:

- Reason for referral: indicate all applicable
  - when selecting "live in crowded dwelling" include # of individuals in the household, along with positive individuals and # of bed and bathrooms in the home
  - if evacuees
  - if Monkeypox

- if other, specify
- Housing Status: indicate if client has a home or if they are either
  - hidden homeless (e.g. staying in transitional housing, hotels, motels, hostels, jails, hospitals or "couch surfing" with family or friends, without a long-term agreement or plan) or
  - absolute homeless (e.g. sleeping outside in tents, bus shelters, cars, doorways, or in empty buildings)

Section 5: Medical Information:

When completing this section complete all applicable, if none are applicable check N/A box

- If client is released from hospital: complete the date of admission and expected date of discharge, day/month/year e.g. 22/Jun/2021
- Reason for admission: indicate diagnoses and treatment plan along with discharge plan
- Hand-off received: indicate N/Y when report has been received from hospital
- Primary Care Provider: indicate physician or nurse practitioner
- Current health condition(s): include all or any relevant health history e.g. Immunocompromised, Cancer 2021
  - select from dropdown; add additional conditions if required by typing in same or refer to selection list
- Current medications: indicate all meds currently being taken and does the client have adequate supply for their isolation period; attach in a separate document if not enough space
- Source of funding: if clients have insurance or are treaty indicate same
- Pregnant: indicate N/Y and # of weeks or indicate if unsure
- Date of next Prenatal Care appointment: indicate date of next appointment, day/month/year e.g. 22/Jun/2021
- Allergies: indicate none known or if yes list all
- EPI pen required: indicate N/Y
- Mobility issues: indicate none or if required what type of assisted devices are utilized
- CPAP: indicate if required N/Y
- ADL Needs: indicate N/Y and if yes specify what help is required
- Home Care Involvement: indicate what services client is receiving
- Dietary Restrictions: indicate what is applicable e.g. gluten free, vegetarian, cultural
- Deaf or hard of hearing: indicate N/Y

Section 6: Mental Health:

When completing this section complete all applicable, if none are applicable check N/A box

- Current Community and Mental Wellness Supports: indicate all being utilized
- Mental health diagnosis/es: indicate N/Y and if yes indicate what type e.g. depression
- Any concerns that will affect the clients stay in isolation: indicate same e.g. is claustrophobic
- Cognitive Concerns: indicate most appropriate and if minimal or significant specify
- History of behavioral needs: indicate if client has and behavioral challenge e.g. aggression
- Any suicidal thoughts in the past 7 days: indicate N/Y and if yes does the client have a plan and when was the last time they expressed the same. Self-harm is defined as the act of purposefully harming oneself.

Section 7: Substance Use:

When completing this section complete all applicable, if none are applicable check N/A box and note if not applicable it is not required to ask any of this section's questions

- Smoker/Vaper: indicate N/Y
- Cannabis use: indicate N/Y
- Client requires wrap-around supports / managed alcohol services: indicate N/Y;
    - *wrap around services:* supporting the clients medical, emotional, spiritual and social needs while in our care;
    - *managed alcohol services:* providing access to alcohol, under the support of the nurse practitioner, to mitigate harms from alcohol use and withdrawal while in isolation
- Substance use: indicate N/Y and what substances have been used. Complete 1st, 2nd and 3rd substance choice with frequency of use for each.
- Preferred method: indicate oral, injection or inhalation
- Supports needed around substance use and isolation: indicate what clients' needs are
- At risk for opioid overdose: indicate N/Y
- Previous overdose history: indicate N/Y and if yes which drugs
- Naloxone kit required: indicate N/Y
- Client is interested in drug treatment or detox services during isolation: indicate N/Y
- Requirement for Opioid Replacement Therapy (ORT): indicate N/Y and whether therapy is already in place
- History of withdrawal seizures: indicate N/Y and whether medications are required for same

Section 8: Family Contact:

- Next of Kin or Family Contact: indicate next of kin or family contact with phone #
- List of Legal Guardians for children under 18: if children are under 18 list any legal guardians with contact info
- CFS involvement: indicate CFS involvement with contact info