GTA REHAB Network

Referral Reference Guide

Referrals from Acute Care to Bedded (Inpatient) Levels of Rehabilitative Care & Complex Continuing Care

September 2018

Introduction

This referral reference guide has been developed to support consistency in the understanding and submission of referral information from acute care to bedded (inpatient) levels of rehabilitative care and Complex Continuing Care (CCC) across organizations within the GTA. Specifically, this guide pertains to the GTA Rehab Network's updated *Integrated Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form (Rev Feb 2018).* The referral reference guide provides the descriptive rationale for how each of the fields within the referral form is to be completed. *The Supplemental Referral Information Form* is an abridged version of the full referral form that can be used to provide updated referral information.

The GTA Rehab Network first developed its *Integrated Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form* following the release of the Provincial Referral Standards (PRS) by the Provincial Standards Sustainability Office (now closed) as part of its Alternative Level of Care, Resource Matching and Referral Business Transformation Initiative in Spring 2014. The PRS was developed to provide a standardized referral data set for referrals from acute care to inpatient rehabilitation and Complex Continuing Care and received province-wide LHIN CEO approval. In Spring/Summer 2014, the GTA Rehab Network engaged Subject Matter Experts (SMEs) from hospitals across all six GTA LHINs to customize the PRS for this region as it was recognized that the complexity of patients in the GTA may require additional referral information.

In January 2018, the Rehabilitative Care Alliance (RCA) updated the PRS to align it with the terminology in the RCA's Definitions Framework for Bedded Levels of Rehabilitative Care. The RCA's bedded Definitions Framework establishes standardized levels of care for bedded (inpatient) rehabilitative care programs. The framework defines eligibility criteria, patient characteristics and the focus and clinical components of each level of rehabilitative care. This clarity supports a common understanding of rehabilitative care among patients, families and referring professionals and creates a foundation to support system and local capacity planning.

The GTA Rehab Network's *Integrated Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form (Rev Feb 2018)* and this referral reference guideline have been updated to reflect these most recent changes.

Referral Reference Guide for *GTA Rehab Network Integrated Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form (Feb 2018)*

Referral Destination		
Data Field	**Rationale for Information**	**Other**
IDENTIFY REFERRAL DESTINATION: ***Bedded Level of Rehabilitative Care*** ☐ *Rehabilitation – High Intensity* ☐ *Complex Medical Management- Short Term* ☐ *Rehabilitation – Low Intensity* ☐ *Complex Medical Management- Long Term* ☐ *Activation/Restoration – Hospital based/Other* ☐ ***Activation/Restoration – Convalescent Care (REFER THROUGH HOME & COMMUNITY CARE)*** ***Complex Continuing Care (CCC)*** ☐ *Other programs (specify):* _____	Specificity of referral destination is needed to ensure that referral is directed to correct intake location (especially for organizations without centralized intake). For definitions of the Bedded Levels of Rehabilitative Care, see page 26.	
If Faxed Include Number of Pages (Including Cover):	This will ensure the Rehab or CCC facility receives the full referral including any attachments	
Estimated Date of Rehabilitative Care /CCC Readiness: DD/MM/YYYY Estimated date of when the patient will be ready for transition into a Rehab/CCC program		

Patient Details and Demographics		
Data Field	**Rationale for Information**	**Other**
Health Card #:	Health card number is required to validate that an individual is entitled to health care services paid by OHIP. (Ministry of Health and Long-Term Care[1])	
Version Code:	If patient has a version code (not all patients will), this version code is part of the validation process.	

[1] Ministry of Health of Health and Long-Term Care (MOHLTC). (2012-12-06). Ministry Programs Ontario Health Insurance Plan (OHIP). Retrieved from http://www.health.gov.on.ca/en/public/programs/ohip/

Patient Details and Demographics		
Data Field	**Rationale for Information**	**Other**
Province Issuing Health Card:	In the event that patient is from out of province, there will be no confusion as to the type of health card and corresponding number.	
No Health Card #: ☐	This is required to capture patients who may not have an Ontario Health Card Number, but are entitled to services paid by OHIP (e.g. Veterans, RCMP); or patients being admitted from out of province or country.	
No Version Code: ☐	Not all patients will have a version code.	
Surname and Given Name(s):	This is used as a patient identifier.	
Home Address, City, Province, Postal Code, Country	This is the address of the patient's home.	***Other Information*** Country is included as Rehab facilities admit out of country patients.
No Known Address: ☐	Some patient populations will not have a home address (e.g. homeless, prison population). This information is helpful for the CCACs to know upfront.	
Telephone # ; Alternate Telephone #; No Alternate Telephone #☐	Primary telephone # for Rehab/CCC facility to contact patient; alternate (e.g. cell phone) if patient cannot be reached at primary number; patient may only have a primary telephone #.	
Current Place of Residence (Complete If Different From Current Address)	This will alert the facility to the address where the patient is currently residing (e.g. temporary residence such as relative's home).	
Date of Birth:	Part of the health card validation process; unique patient identifier.	

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Gender: ☐ M ☐ F ☐ Other	Patient identifier. May be required for room accommodation.	
Marital Status:		
Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No Primary Language: ☐ English ☐ French ☐ Other	To ensure the Rehab/CCC facility is able to converse with patient and identify if an interpreter will be required to have a fulsome understanding of assessments and services required to support the patient needs. Information will also be shared with other HSPs so that they can prepare to meet the patient needs.	***Acronym*** **HSPs**- Health Service Providers
Primary and Secondary Alternate Contact Person	Primary contact person (other than patient) and/or secondary contact. This may be a legal or non-legal contact. Also used as emergency contact if required.	
Relationship to Patient: ☐POA ☐ SDM ☐Spouse ☐Other	Describes the role of the primary and secondary contacts as it relates to legal or non-legal decisions of the patient's care. More than one option can be selected at the same time, i.e. "Spouse" and "POA".	***Acronyms and Definitions*** **POA**-Power of Attorney **SDM-**Substitute Decision Maker
		Spouse-Partnership in marriage, civil union, domestic partnership, common-law. **Other**-Daughter, son, or another individual who plays a social role
Telephone # ; Alternate Telephone #;	Primary and alternate telephone # where contacts can be reached.	

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Responsibility for Payment: Insurance: N/A: ☐	Insurance number and carrier name. Private insurance required for out of province and out of country patients. Insurance is also required in addition to OHIP for Ontario patients requesting preferred accommodations that are not covered by OHIP. In some situations Insurance is not required thus the N/A field.	***Specific to CCC*** Co-payment is specific to this pathway. Prior to the CCC application being sent, it is important that a discussion has taken place with the patient or SDM/POA/family to ensure they are aware of their financial responsibilities. (MOHLTC [4])
For CCC Only – Co-payment discussed with: ☐ Patient ☐ Other	It is important that a discussion take place prior to the CCC application being sent as payment is always required for this service in Cluster 2.	***Specific to CCC*** Co-payment is specific to this pathway. Prior to the CCC application being sent, it is important that a discussion has taken place with the patient or SDM/POA/family to ensure they are aware of their financial responsibilities. (MOHLTC [3])
☐ OHIP ☐ Federal Government ☐ IFH (Interim Federal Health Grant) ☐ Inter-provincial Insurance Plan ☐ Insured/Self Pay ☐ Other Payment Sources ☐ WSIB ☐ Uninsured/Self Pay ☐ Unknown	In addition to rationale noted above, specifying the details for responsibility for payment assists in identifying potential delays/difficulties in processing the referral application and admission.	
Preferred accommodation: ☐ Ward ☐ Semi private ☐ Private ☐ Other (specify): __		
Rehab/CCC Population Requested: ☐ ABI ☐ Amputee ☐ Burns ☐ Cardiac ☐ Chronic Ventilation ☐ General/Medical ☐ Geriatric ☐ MSK ☐ Neuro ☐ Oncology ☐ Respiratory Rehab ☐ Spinal Cord ☐ Stroke ☐ Trauma ☐ Transplant ☐ Other _____	Type of Rehab and CCC program the sender is requesting for the patient.	

Patient Details and Demographics		
Data Field	**Rationale for Requested Information**	**Other**
Current Location Name:	Location of the Hospital where the patient currently is residing. To identify where the patient is located and can be contacted.	
Current Location Address; City; Province, Postal Code	Contact information for the Hospital where the patient is currently residing. To identify where the patient is located and can be contacted.	
Current Location Contact Number:	Contact number for the Hospital unit where the patient is currently residing, in the event that the receiving facility requires further information related to the patient.	
Bed Offer Contact (Name and Number):	Contact number for unit staff at the sending facility for notification of bed offer.	
Medical Information		
Data Field	**Rationale for Requested Information**	**Other**
Primary Health Care Provider (e.g. MD, NP) None: ☐	The referring Physician/Designate i.e. the Attending Physician in the acute care hospital that is making the referral.	***Acronyms*** **MD**- Medical Doctor **NP-** Nurse Practitioner
Surname; Given Name(s)	Primary Care Provider's last and first name.	
Reason for Referral:	Example; Patient to return to pre-morbid level of function and/or current multi-system needs.	

Medical Information		
Data Field	**Rationale for Information**	**Other**
Allergies: ☐ No Known Allergies ☐ Yes---If Yes, List	The lack of Allergy information could have devastating impacts on patient safety and care and therefore it is important that the sending facility documents all relevant allergies (Drug, Food, Latex etc.) upfront in the referral process to alert the receiving facility.	
Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ C. diff ☐ ESBL ☐ TB ☐ Other(Specify)	To alert the receiving facility if the patient requires any Infection Control practices and/or accommodations when providing care (e.g. private room, personal protective equipment).	***Acronyms and Definitions*** **None-** Patient is negative for the following pathogens and does not require Infection Control practices; if one of the boxes is checked off, patient is considered positive. **MRSA-**Methicillin- resistant Staphylococcus aureus **VRE-** Vancomycin-resistant Enterococcus **C. diff-**Clostridium difficile **ESBL-** Extended-Spectrum Beta-Lactamas- Producing Bacteria **TB-**Tuberculosis **Other-**patient may be isolated or may require Infection Control practices related to diarrhea, or symptoms of unknown etiology. (PIDAC, 2013[2])

Medical Information		
Data Field	**Rationale for Information**	**Other**
Admission Date: Date of Injury: Surgery Date:	Provides a snapshot of the patient's journey by providing a timeline form injury to post-op to appropriate program.	
Nature/Type of Injury/Event:	Description of injury (e.g. stroke, spinal cord injury, medically complex).	
Primary Diagnosis:	Diagnosis on admission; the condition that motivated the initial hospitalization.	
History of Presenting Illness/Course in Hospital:	Clinical course of patient during hospitalization (e.g. presenting symptoms, infections, surgical complications).	
Current Active Medical Issues/Medical Services following Patient:	Current active medical issues that are being followed by other medical services (e.g. Nephrology, Cardiology).	
Past Medical History:	Historical perspective and account of the patient's past medical needs or crisis. Includes describing any past major illnesses, surgeries, and patient's health status prior to the presenting problem (e.g. current or ongoing medical conditions such as diabetes).	
Attach the following: Medication: ☐ MAR Lab Work: ☐ If indicated, send most recent lab work (e.g. Haemoglobin, white blood cell count, lytes, creatinine)	Attach information on the patient's medications and recent lab work. These serve to identify medications that may not be readily accessible in the rehab/CCC setting and to provide additional information on the patient's functional status.	
Height and Weight:	Required to determine bariatric needs. This information is helpful in identifying if the receiving facility can accommodate the patient.	

Medical Information		
Data Field	**Rationale for Information**	**Other**
Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days Location: **If Dialysis Centre is located off-site from rehab/CCC, indicate how patient will access Dialysis Centre:** ☐ Family drives ☐ Volunteer drives ☐ Wheel-Trans ☐ Other ____	To determine if the facility can accommodate/support the treatment on site. To determine if the frequency of the treatments and travel time will not impact the patient's ability to participate in the program. Transportation requirements would need to be assessed.	***Examples*** **Frequency:** e.g. Daily, 3 X weekly **Days**: e.g. M-W-F **Location**: Where treatment will take place (e.g. off-site, on-site)
Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No Frequency: Duration: Location	Refer to Dialysis	***Examples and Definition*** **Frequency**; How often the patient receives treatments (e.g. daily, weekly, monthly) **Duration:** Length of time required to receive the treatment.
Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No Frequency: Duration: Location:	Refer to Dialysis	Refer to Chemotherapy
Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ NO ☐ Details	Refer to Dialysis	
Medical Prognosis ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative ☐ Unknown Palliative Performance Scale	Prediction of the probable outcome of the course of the disease and/or patient's health. This information is provided by a physician, but it is important to note that although a physician provides this information, they do not necessarily have to complete the actual referral form to do so. The physician can provide this information through any document, and the person filling out the form (NP, RN or other) can then just transcribe the physician noted information into the referral form.	

Medical Information		
Data Field	**Rationale for Information**	**Other**
Advanced Medical Directives	As an example, stand-alone facilities would want to know advanced directives for patients with chronic vents.	
Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other	Allied Health Services consulted in the care of the patient during the course of their hospitalization.	***Acronyms*** **PT**- Physiotherapy **OT**-Occupational Therapy **SW**- Social Work
Pending Investigations: ☐ Yes ☐ No Details	Scheduled or pending investigations not completed (e.g. MRI) This information may be pertinent in determining patient acceptance and type of program required.	
Frequency of Lab Tests: ☐ Unknown ☐ None	Transportation requirements may be needed if lab tests cannot be accommodated on site. Also to determine impact on patient's participation in the program and ability to participate.	
Study Medications: ☐ Yes ☐ No Details	This field prompt clinicians to seek out information, if relevant to the referral. Rehab/CCC facility may not be able to support Study Medications.	

Respiratory Care Requirements			
Data Field		**Rationale for Requested Information**	**Other**
Does the Patient Have Respiratory Care Requirements? ☐ Yes ☐ No --- If No Skip to Next Section		This question is intended to prompt the sender to include any respiratory care requirements to ensure the receiving facility has the equipment and staff trained to support the patient. Patients referred to CCC programs often require specialized respiratory care and equipment to support their health.	
Supplemental Oxygen: ☐ Yes ☐ No	Ventilator: ☐ Yes ☐ No		
☐ Target 02 Sat _____ L/min ☐ Intermittent Oxygen _____ L/min ☐ Constant Oxygen _____L/min ☐ 02 at rest _____ L/min ☐ 02 at exercise_____ L/min		Information on oxygen care needs is required to ensure that receiving facility is able to accommodate resource needs, particularly for any special oxygen equipment or human resources that the patient needs.	
Special Oxygen Equipment/Human Resources required? (e.g. rebreather, optiflow, specialized resources of Respiratory Therapist): ☐ No ☐ Yes (specify): _____			
Breath Stacking: ☐ Yes ☐ No		Insufflation/Exsufflation ☐ Yes ☐ No	
Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless Type: Size:			
Suctioning: ☐ Yes ☐ No Frequency:			***Example:*** **Frequency**: This describes how often the patient requires suctioning (e.g. hourly, or as required)

Respiratory Care Requirements		
Data Field	**Data Field**	**Data Field**
C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No		
Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No		
Additional Comments:	Provide any information that has not been shared but is critical to ensure a safe transition to Rehab or CCC.	

IV Therapy		
Data Field	**Rationale for Requested Information**	**Other**
IV in Use: ☐ Yes ☐ No--- If No skip to Next Section	To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	***Acronym*** **PICC**- Peripherally Inserted Central Catheter
IV Therapy: ☐ Yes ☐ No		
Central Line: ☐ Yes ☐ No		
PICC Line: ☐ Yes ☐ No		
Name of IV Medication:		

Hearing/Vision		
Data Field	**Rationale for Requested Information**	**Other**
Hearing: ☐ Intact, can hear routine conversation ☐ Intact, with hearing aid ☐ Reduced hearing ☐ Completely impaired ☐ American Sign Language Vision: ☐ Intact ☐ Intact with visual aid ☐ Visual field deficit ☐ Double vision ☐ Completely impaired	This provides additional information on the patient's functional status and serves to highlight if any environmental modifications or supports are required to assist and ensure patient safety. If patient is legally blind, please comment if s/he has support in place (e.g. CNIB)	
Swallowing and Nutrition		
Data Field	**Rationale for Requested Information**	**Other**
Swallowing Deficit: ☐ Yes ☐ No	To identify that patient may have special needs related to the swallowing deficit.	
Swallowing Assessment Completed: ☐ Yes ☐ No	If yes, information in report will be of benefit to the receiving facility and will outline plan of care; if No facility may not have the ability to complete assessment on site and may require completion prior to accepting the patient. It is our understanding that any information related to the swallowing assessment is part of the speech pathology reports under (other consultative reports section) of the referral form.	
Type of Swallowing Assessment and Details:	Information that will help determine best program and care for patient.	
TPN: ☐ Yes (If Yes, Include Prescription with Referral) ☐ No	To ensure the receiving facility has the equipment and staff trained to support the patient's needs. To ensure Pharmacy has the ability to prepare or obtain the solution required.	***Acronym*** **TPN**-Total Parenteral Nutrition

Swallowing and Nutrition		
Data Field	**Rationale for Requested Information**	**Other**
Enteral Feeding: ☐ Yes ☐ No ☐ Tube Type: _____ ☐ Specify Formula Type & Rate of Feeds: _____	To ensure the receiving facility has the equipment, formula type and staff trained to support the patient's needs.	
Diet: ☐ Regular ☐ Kosher ☐ Diabetic ☐ Renal ☐ Low Sodium ☐ Other (specify): _____	Indicate the type of diet that the patient requires to ensure availability upon admission.	

Falls		
Data Field	**Rationale for Information**	**Other**
Does Patient Have a History of Falls? ☐ Yes ☐ No If yes, specify: ☐ home/community ☐ hospital History & Frequency: ☐ Frequent ☐ Rare ☐ Intermittent	To ensure that receiving facility has a clear understanding of whether the patient has a history of falls, the reasons for the falls and if the patient is at risk of falls upon admission. This information also adds to the understanding of the patient's functional status.	
Reason for most recent fall(s): ☐ Balance ☐ Vision ☐ Strength ☐ Fatigue ☐ Decreased insight/judgment ☐ Unknown ☐ Other (list):	Describe circumstances of falls, frequency, triggers, strategies implemented to reduce risk of falls.	

Skin Condition		
Data Field	**Rationale for Requesting Information**	**Other**
Surgical Wounds and/or Other Wounds Ulcers: ☐ Yes ☐ No--- If No, Skip to next Section	Required to alert receiving facility of required wound care support. To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	

Skin Condition		
Data Field	**Rationale for Requesting Information**	**Other**
Location: Stage:	To ensure the receiving facility has the equipment (VAC or Negative Pressure Wound Therapy) and staff trained to support the patient's needs. Facility may not be able to support wound management care plan. Frequency and time to complete dressing is required to review impact on the patient's time to participate in the program.	***Definition and Acronym*** **Location**: This is the location of the wound or ulcer on the patient body.
Dressing Type: Frequency: (e.g. Negative Pressure Wound Therapy or VAC)		**VAC**-Vacuum Dressing **Frequency**: How often the dressing is changed (e.g. daily, twice daily)
Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes		
** If additional wounds exist, add supplementary information on a separate sheet of paper.*	Supplementary information can be part of the attachments included with the referral.	

Continence		
Data Field	**Rationale for Requesting Information**	**Other**
Is Patient Continent: ☐ Yes ☐ No--- If Yes, Skip to Next Section	Required for patient care planning.	
Bladder Continent: ☐Yes ☐ No If No: ☐ Occasional Incontinence ☐Incontinent		

Continence		
Data Field	**Rationale for Requesting Information**	**Other**
Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent		
Ostomy: ☐ N/A ☐ Yes **Type/brand and care/products required** _____ Ability to care for ostomy: ☐ Independent ☐ Total care ☐ Requires supervision	Information regarding ostomy care needs is required to support preparation for admission to receiving facility.	

Pain Care Requirements		
Data Field	**Rationale for Information**	**Other**
Does the Patient Have a Pain Management Strategy: ☐ Yes ☐ No ---If No, Skip to Next Section	Patient's ability to participate successfully in a program is dependent upon controlled pain. Receiving facility may request pain management plan prior to accepting patient.	
Controlled With Oral Analgesics: ☐ Yes ☐ No	This information will provide the facility with the type of care needs required to support the patient.	
Medication Pump: ☐ Yes ☐ No		
Methadone: ☐ Yes ☐ No		
Epidural: ☐ Yes ☐ No		
Has a Pain Plan of Care Been Started: ☐ Yes ☐ No	Patient's ability to participate successfully in a program is dependent upon controlled pain.	

Communication		
Data Field	**Rationale for Information**	**Other**
Does the Patient Have a Communication Impairment: ☐ Yes ☐ No ---If No, Skip to Next Section	This information will provide the facility with the type of care needs required to support the patient.	
Communication Impairment Description:	Describe the type of communication impairment (e.g. Aphasia, articulation problems).	

Cognition					
Data Field				**Rationale for Information**	**Other**
Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess---If No, or Unable to Assess, Skip to Next Section				Required to understand if patient's cognition will impair ability to participate in the program. The type of cognitive impairment will determine the appropriate Rehab or CCC program.	
Details on Cognitive Deficits:					
Has the Patient Shown the Ability to Learn and Retain Information: ☐ Yes ☐ No--- If No, Details:				If the patient's ability to learn and retain information is impaired, include information on whether issues can be mitigated through caregiver support or other environmental cues/considerations.	
Cognitive Status (Complete Table Below)	**Not Tested**	**Intact**	**Impaired (specify)**	Detailed information on each of these areas of cognition (if tested) provides a clear picture of the patient's cognitive impairments, ability to participate in rehabilitation and rehabilitation needs.	
Orientation Attention Able to follow instructions Memory (short term) Memory (long term) Judgment Insight Frustration Tolerance (ABI only) Other				In completing this section, consider: Attention – Specify types of attention; strategies used Short Term Memory – Comment on way finding, compensatory strategies, ability to recognize the health care provider Judgment – Comment on areas which might be influenced by impairment Insight – Comment on the insight patient has; strategies used; if impaired, does patient understand aspects of cognition which require therapy?	
				Frustration Tolerance – How does frustration tolerance impact the therapeutic session?	

Cognition					
Data Field				**Data Field**	**Data Field**
☐ MMSE Score: _____ *or* ☐ MoCA Score: _____				Folstein MF, Folstein SE, McHugh PR (1975). ""Mini-mental state". A practical method for grading the cognitive state of patients for the clinician". *Journal of Psychiatric Research* **12** (3): 189–98 http://www.mocatest.org/	
Rancho Los Amigos Cognitive Scale at present: (ABI only):				http://www.neuroskills.com/resources/rancho-los-amigos-revised.php	
Delirium: ☐ Yes ☐ No--- If Yes, Cause/ Details:				Delirium can be attributed to several things (e.g. Chronic condition; infection, medications, surgery and drug/alcohol abuse). This will be important information for the receiving facility when determining the appropriate program for the patient.	
History of Diagnosed Dementia: ☐ Yes ☐ No				People with dementia require skilled interventions in a controlled environment. The receiving facility will want to ensure they can support this type of patient safely.	

Behaviour		
Data Field	**Rationale for Information**	**Other**
Are There Behavioural Issues: ☐ Yes ☐ No--- If No, Skip to Next Section	People with challenging behaviours require skilled interventions in a controlled environment. The receiving facility will want to ensure they can support the patient safely. This includes the facility having the type of environment that the patient requires (e.g. secure unit).	
Does the Patient Have a Behaviour Management Strategy: ☐ Yes ☐ No		
Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering ☐ Sundowning ☐ Exit-Seeking ☐ Resisting Care ☐ Other ☐ Restraints---If Yes, Type/Frequency Details: Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one.		

Social History		
Data Field	**Rationale for Information**	**Other**
Discharge Destination: ☐ Multi-Storey ☐ Bungalow ☐ Apartment ☐ LTC ☐ Retirement Home (Name)	Discharge destination will help to direct patient's Rehab/CCC goals and supporting care plan. If patient does not have a discharge destination in place, work will be required to find a suitable discharge destination; receiving facility may request a repatriation agreement with the sending facility in the event a discharge destination is not found.	
Accommodation Barriers: ☐ Unknown	Accommodation barriers that must be dealt with prior to the patient returning home. This becomes part to the patient care plan (e.g. stairs).	
Smoking: ☐ Yes ☐ No ☐ Details Alcohol and/or Drug Use: ☐ Yes ☐ No ☐ Details	Smoking assessment and care plan may be required as the receiving facility may not be able to support the patient's smoking needs; or drug/alcohol withdrawal needs (e.g. Methadone).	
Previous Community Supports: ☐ Yes ☐ No ☐ Details	Helpful for determining care planning needs.	
Discharge Planning Post Hospitalization Addressed: ☐Yes☐ No ☐ Details	To ensure the patient or SDM clearly understands his/her discharge destination and targeted length of stay. Include information on the availability of family support during admission.	***Acronym*** **SDM**-Substitute Decision Maker
Discharge Plan Discussed with Patient/SDM: ☐ Yes ☐ No		

Current Functional Status		
Data Field	**Rationale for Information**	**Other**
Patient Goals:	This describes for the receiving facility the goals for care and successful discharge. Goals should be specific, measurable, achievable, realistic and timely.(e.g. Mrs. Smith will feed herself independently with set up in 1 month; Mr. Jones will walk indoors independently without a gait aid in 3 months).	***Other Information*** Important to note patient goals for both Rehab and CCC depending on the program the patient is being referred to.
Participation Level: Specify: On average, patient is able to participate in ___therapy sessions / day, ___times / week for __minutes / session	Provides a clear picture of the patient's ability to participate in rehab with respect to the intensity of rehabilitation that the patient can tolerate upon admission.	
Sitting Tolerance: ☐ More Than 2 Hours Daily ☐ 1-2 Hours Daily ☐ Less Than 1 Hour Daily ☐ Has not Been Up	Patient functional status information will help direct patient to most appropriate program which will enhance patient's independence. Physical tolerance will help the receiver understand the patient's functional ability to participate and direct to the appropriate program (e.g. high tolerance program, low tolerance program).	
Transfers: ☐ Independent ☐ Supervision ☐ Assist X1 ☐ Assist X2 ☐ Mechanical Lift	Information on Stairs may have impact to accept decision. Some Rehab facilities have programs specific to enhance patient's independence with stairs, other rehab facilities do not.	
Ambulation: ☐ Independent ☐ Supervision ☐ Assist X1 ☐ Assist X2 ☐ Unable Number of Meters:	**Weight Bearing Status** Treating therapists need to know degree of weight-bearing ordered by physician. Length of non-weight-bearing status is important consideration for access to some programs.	
Stairs: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Stair Lift/Glide	Full details on weight bearing status and limb impairment for right and left limbs and upper/lower extremity has implications for ensuring correct precautions are taken and that the functional impact relative to other impairments are known.	

Current Functional Status		
Data Field	**Rationale for Information**	**Other**
Weight Bearing Status: ☐ Full ☐ As Tolerated Left: ☐ U/E ☐ L/E ☐ Full ☐ As Tolerated ☐ Partial _____% ☐ Toe Touch ☐ Non: Date expected to be weight-bearing _____ DD/MM/YYYY	**Definitions for Weight Bearing Status** Full= The patient may place their full body weight on the affected leg when standing or walking As Tolerated= When walking or standing the patient evenly distributes their weight through their legs and may place only as much weight as feels comfortable on the affected leg. Pain will be the guide for the patient as they feel pain they should place less weight on the affected leg. Partial= When the patient stands or walks they may place a percentage of their body weight on the affected leg – this will be at the direction of their physician.	
Right: ☐ U/E ☐ L/E ☐ Full ☐ As Tolerated ☐ Partial _____% ☐ Toe Touch ☐ Non: Date expected to be weight-bearing _____ DD/MM/YYYY		
Limbs: ☐ U/E impairment ☐ L/E impairment ☐ Aid(s) Required: _____	Toe Touch= When the patient stands or walks they may touch the floor only for balance and do not place actual full weight on their affected leg; almost all of their weight is taken through the arms with the aid of a walker or crutches.	
Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist X1 ☐ Assist X2	Non= The patient cannot place any weight on their affected leg. Do not touch the floor with the affected leg. While standing or walking they must hold their affected leg off the floor. Reference: Thunder Bay Regional Health Sciences, Total Joint Clinical Pathway Team 2008. Retrieved from http://www.tbrhsc.net/site_wide_references/surgical_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20(Restricted%20Weight%20Bearing).pdf	

<table>
<tr><th colspan="8">Activities of Daily Living</th></tr>
<tr><th colspan="7">Data Field</th><th>Rationale for Requesting Information</th><th>Other</th></tr>
<tr><td colspan="7">Describe Level of Function Prior to Hospital Admission (ADL & IADL)

Current Status Table-Complete the Table Below</td><td rowspan="2">To have an understanding of the patients premorbid level of functioning and a baseline to gauge the patient’s progress.</td><td>Acronyms
ADL-Activities of Daily Living</td></tr>
<tr><td colspan="7"></td><td>IADL-Instrumental Activities of Daily Living</td></tr>
<tr><td>Activity</td><td>Independent</td><td>Cueing/ Set/Up or Supervision</td><td>Min. Assist</td><td>Mod. Assist</td><td>Max Assist</td><td>Total Care</td><td rowspan="8">To understand patients current functional status and ability to perform activities of daily living independently.

Other Information
Currently there are no standardized assessment tools for the Rehab and CCC programs. There are no common definitions used across the province that define:
Independent; Cueing/Setup or Supervision; Minimum Assist; Moderate Assist; Maximum Assist; Total Care.</td><td rowspan="8">Across the province sites are using either the RAI HC-ADL Self-Performance[6]; the AlphaFIM®[7]- levels of function description and ratings or other Health Service Provider assessment tools or criteria for completing the ADL section. For the Initial Implementation the Provincial Delivery and Project Sponsor will collect feedback on the use of existing resources leveraged by the participating sites to complete the ADL section. In addition we will be adding specific questions in our Rehab and CCC evaluation surveys to help with the assessment of the ADL section. For your reference Appendix D and E provides the definitions from the RAI HC and the AlphaFIM® instrument.</td></tr>
<tr><td>Eating</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Grooming</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dressing</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dressing</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Toileting</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Bathing</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><th colspan="5">Special Equipment Needs</th></tr>
<tr><th colspan="3">Data Field</th><th>Rationale for Requesting Information</th><th>Other</th></tr>
<tr><td colspan="3">Special Equipment Required: ☐ Yes ☐ No--- If No, Skip to next Section</td><td rowspan="5">To ensure the receiving facility has the equipment and staff trained to support the patient's needs.</td><td rowspan="5"></td></tr>
<tr><td colspan="3">☐ Halo ☐ Orthosis ☐ Bariatric ☐ Other</td></tr>
<tr><td colspan="3">Pleuracentesis: ☐ Yes ☐ No; Drain: : ☐ Yes ☐ No – if yes, please enter type/details

Paracenteisis : ☐ Yes ☐ No; Drain: : ☐ Yes ☐ No – if yes, please enter type/details</td></tr>
<tr><td colspan="3">Need for Special Mattress: Yes/No</td></tr>
<tr><td colspan="3">Negative Pressure Wound Therapy: Yes/No</td></tr>
<tr><th colspan="5">Rehabilitative Care Specific - AlphaFIM® Instrument</th></tr>
<tr><td colspan="3">AlphaFIM® Data Available: ☐ Yes ☐ No--- If No, Skip to Next Section</td><td rowspan="5">AlphaFIM® provides a consistent method of assessing patient disability and functional status in the acute care setting. The Alpha-FIM® instrument helps clinicians to obtain expected FIM® ratings, evaluate expected discharge status, and project expected minutes of care. These ratings can then be used to assign a probable discharge disposition from the acute care setting and can be converted into expected minutes of patient care, which help staff and family members understand the patient's resource needs for performing activities of daily living (Uniform Data System for Medical Rehabilitation[5]).

AlphaFIM® results provided with the Rehab and CCC Provincial Referral Standards will be provided by those health service providers who are trained and licenced to use this instrument.</td><td rowspan="5">Trademark/Copyright notice added at bottom of last page of Rehab/CCC referral as requested by UDSMR :

"AlphaFIM and FIM are trademarks of Uniform Data System for Medical Rehabilitation (UDSMR), a division of UB Foundation Activities, Inc. All Rights Reserved. The AlphaFIM items contained herein are the property of UDSMR and are reprinted with permission."</td></tr>
<tr><td colspan="3">Has the Patient Been Observed Walking 150 Feet or More: ☐ Yes ☐ No</td></tr>
<tr><td rowspan="2">If Yes- Raw Ratings(rate levels 1-7):</td><td>Transfers: Bed, Chair</td><td>Expression</td><td>Transfers: Toilet</td></tr>
<tr><td>Bowel Management</td><td>Locomotion: Walk</td><td>Memory</td></tr>
<tr><td rowspan="2">If No- Raw Ratings(rate levels 1-7):</td><td>Eating</td><td>Expression</td><td>Transfers: Toilet</td></tr>
<tr><td>Bowel Management</td><td>Grooming</td><td>Memory</td></tr>
<tr><td rowspan="2">Projected:</td><td>FIM® projected Raw Motor(13)</td><td>FIM® projected Cognitive (5)</td><td></td></tr>
<tr><td>Help Needed</td><td></td><td></td></tr>
</table>

Attachments		
Data Field	**Rationale for Requesting Information**	**Other**
Details on other relevant information that would assist with this referral:	Any pertinent information specific to the patient that might not have been captured in the referral but will help the receiver with their decision making process and patient care planning.	
Please Include with this Referral: ☐ Admission History and Physical ☐ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician) ☐ All Relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US, etc.) ☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology, and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)	These attachments were deemed necessary by Subject Matter Experts as required information to make an accept decision into the Rehab or CCC program.	***Acronyms*** **PT**-Physiotherapy **OT**- Occupational Therapy **SLP-** Speech Language and Pathology **SW**- Social Work **US-**Ultra Sound
Completed by; Title; Date; Contact Number; Direct Unit Phone Number.	The person completing the referral must be identified in the event that the receiving facility requires follow-up information related to the patient and referral. Contact # and direct unit phone provides the facility with specific line to call.	
If Faxed Include Number or Pages (Including Cover)	This will ensure that the Rehab or CCC referral is received in full and that no information is missing.	

Key Features of the Bedded Levels of Rehabilitative Care

For full descriptions of each level, see the Rehabilitative Care Alliance's Definitions Framework for Bedded Levels of Rehabilitative Care available at http://rehabcarealliance.ca/definitions-1

Rehabilitation	Activation/Restoration	Short-Term Complex Medical Management	Long-Term Complex Medical Management
Functional Goal: *Progression* *Time-limited, coordinated interprofessional rehabilitation plan of care ranging from low to high intensity through a combined and coordinated use of medical, nursing and allied health professional skills.* **Target Population:** Medically stable, able to participate in comprehensive rehabilitation program **Average LOS**: <90 Days. Based on best practice targets and discharge indicator considerations. Rehab team to confirm LOS for specific program. **Discharge Indicator:** Rehab goals met, access to MD/nursing care no longer required **Medical Care:** Daily physician access **Nursing Care:** Up to 3 hrs/day. Some may go up to 4 hrs. **Therapy Care:** Direct care by regulated health professionals and as assigned to non-regulated professionals **Therapy Intensity:** 15-30 mins of therapy 3x/day to 3 hrs/day. Based on patient's tolerance.	***Functional Goal:*** *Progression* *Exercise and recreational activities offered to increase strength and independence. Goal achievement does not require daily access to a full interprofessional rehabilitation team & coordinated team approach.* **Target Population:** Medically stable, cognitively and physically able to participate in restorative activities **Average LOS**: (56-72 days) <90 Days **Discharge Indicator:** Rehab goals met, access to MD/nursing care no longer required **Medical Care:** Weekly physician access/follow-up **Nursing Care:** <2 hrs/day **Therapy Care:** Consulted by regulated health professionals, delivered mostly by non-regulated professional as assigned **Therapy Intensity:** Group or 1:1 setting, throughout the day 30 mins or up to 2 hrs/day (5-7 days/week).	***Functional Goal:*** *Stabilization & Progression* *Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.* **Target Population:** Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support. On admission, may have limited physical and/or cognitive capacity due to medical complexity but believed to have restorative potential. **Average LOS**: Up to 90 Days **Discharge Indicator:** Medical/functional recovery to allow patient to safely transition to next level of rehab care or alternate environment **Medical care:** Access to scheduled physician care/daily medical oversight **Nursing Care:** >3hrs /day **Therapy Care:** Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professionals as assigned. **Therapy Intensity:** Up to 1 hr, as tolerated by the patient	***Functional Goal:*** *Maintenance* *Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function* **Target Population:** Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support that cannot be met at home or in a LTCH **Average LOS**: Will remain at this level **Discharge Indicator:** Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes **Medical care:** Access to weekly physician follow up/oversight – up to 8 monitoring visits per month **Nursing Care:** >3hrs /day **Therapy Care:** Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professional as assigned. **Therapy Intensity:** Regulated health professional available to maintain and optimize functional abilities.

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