



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

September 2020

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*). 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* and this referral reference guideline were updated accordingly.

In June 2020, the GTA Rehab Network's *Integrated Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form* and this referral reference guideline were updated again with new fields pertinent to capturing information on the rehabilitative care needs of patients during the COVID-19 pandemic.

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
<p>IDENTIFY REFERRAL DESTINATION: <u>Bedded Level of Rehabilitative Care</u> <input type="checkbox"/> Rehabilitation – High Intensity <input type="checkbox"/> Complex Medical Management- Short Term <input type="checkbox"/> Rehabilitation – Low Intensity <input type="checkbox"/> Complex Medical Management- Long Term <input type="checkbox"/> Activation/Restoration – Hospital based/Other <input type="checkbox"/> Activation/Restoration – Convalescent Care (<u>REFER THROUGH HOME & COMMUNITY CARE</u>) <u>Complex Continuing Care (CCC)</u> <input type="checkbox"/> Other programs (specify): _____</p>	<p>Specificity of referral destination is needed to ensure that referral is directed to correct intake location (especially for organizations without centralized intake).</p> <p>For definitions of the Bedded Levels of Rehabilitative Care, see page 26.</p>	
<p>If Faxed Include Number of Pages (Including Cover):</p>	<p>This will ensure the Rehab or CCC facility receives the full referral including any attachments</p>	
<p>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</p>		
Patient Details and Demographics		
Data Field	Rationale for Information	Other
<p>Health Card #:</p>	<p>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 Care¹)</p>	
<p>Version Code:</p>	<p>If patient has a version code (not all patients will), this version code is part of the validation process.</p>	

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 #: <input type="checkbox"/>	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: <input type="checkbox"/>	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: <input type="checkbox"/>	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 # <input type="checkbox"/>	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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Patient identifier. May be required for room accommodation.	
Marital Status:		
Patient Speaks/Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other	To ensure the Rehab/CCC facility is able to converse with patient and identify if an interpreter will be required to have a full 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: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> 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: <input type="checkbox"/>	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: <input type="checkbox"/> Patient <input type="checkbox"/> 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)
<input type="checkbox"/> OHIP <input type="checkbox"/> Federal Government <input type="checkbox"/> IFH (Interim Federal Health Grant) <input type="checkbox"/> Inter-provincial Insurance Plan <input type="checkbox"/> Insured/Self Pay <input type="checkbox"/> Other Payment Sources <input type="checkbox"/> WSIB <input type="checkbox"/> Uninsured/Self Pay <input type="checkbox"/> 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: <input type="checkbox"/> Ward <input type="checkbox"/> Semi private <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): ___		
Rehab/CCC Population Requested: <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> Chronic Ventilation <input type="checkbox"/> General/Medical <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neuro <input type="checkbox"/> Oncology <input type="checkbox"/> Respiratory Rehab <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Stroke <input type="checkbox"/> Trauma <input type="checkbox"/> Transplant <input type="checkbox"/> 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: <input type="checkbox"/>	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: <input type="checkbox"/> No Known Allergies <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C. diff <input type="checkbox"/> ESBL <input type="checkbox"/> TB <input type="checkbox"/> COVID-19 (Specify details below) <input type="checkbox"/> 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.
COVID-19: Date of symptom onset/diagnosis: _____ List of symptoms: _____	1st Test: _____ DD/MM/YYYY 2 nd Test: _____ DD/MM/YYYY	Information on COVID-19 has been added to identify rehabilitative care and infection prevention and control needs.
		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 from 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: <input type="checkbox"/> MAR Lab Work: <input type="checkbox"/> 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
<p>Is Patient Currently Receiving Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis Frequency/Days Location: If Dialysis Centre is located off-site from rehab/CCC, indicate how patient will access Dialysis Centre: <input type="checkbox"/> Family drives <input type="checkbox"/> Volunteer drives <input type="checkbox"/> Wheel-Trans <input type="checkbox"/> Other ____</p>	<p>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.</p>	<p>Examples</p> <p>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)</p>
<p>Is Patient Currently Receiving Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: Duration: Location</p>	<p>Refer to Dialysis</p>	<p>Examples and Definition</p> <p>Frequency; How often the patient receives treatments (e.g. daily, weekly, monthly) Duration: Length of time required to receive the treatment.</p>
<p>Is Patient Currently Receiving Radiation Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: Duration: Location:</p>	<p>Refer to Dialysis</p>	<p>Refer to Chemotherapy</p>
<p>Concurrent Treatment Requirements Off-Site: <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Details</p>	<p>Refer to Dialysis</p>	
<p>Medical Prognosis</p> <p><input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Palliative <input type="checkbox"/> Unknown Palliative Performance Scale</p>	<p>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.</p>	

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: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SW <input type="checkbox"/> Speech and Language Pathology <input type="checkbox"/> Nutrition <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Unknown <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Details	This field prompts 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
Was the patient intubated as part of their care?" <input type="checkbox"/> Yes Number of days _____ <input type="checkbox"/> No	This field was added during the COVID-19 pandemic to identify potential care needs.	
Supplemental Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No Ventilator: <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Target O2 Sat _____ L/min <input type="checkbox"/> Intermittent Oxygen _____ L/min <input type="checkbox"/> Constant Oxygen _____ L/min <input type="checkbox"/> O2 at rest _____ L/min <input type="checkbox"/> O2 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): <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____		
Breath Stacking: <input type="checkbox"/> Yes <input type="checkbox"/> No Insufflation/Exsufflation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cuffed <input type="checkbox"/> Cuffless Type: _____ Size: _____		
Suctioning: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____		Frequency Example: This describes how often the patient requires suctioning (e.g. hourly, as required)

Respiratory Care Requirements

Respiratory Care Requirements		
Data Field	Data Field	Data Field
C-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bi-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No Rescue Rate: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Central Line: <input type="checkbox"/> Yes <input type="checkbox"/> No		
PICC Line: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of IV Medication:		

Hearing/Vision		
Data Field	Rationale for Requested Information	Other
Hearing: <input type="checkbox"/> Intact, can hear routine conversation <input type="checkbox"/> Intact, with hearing aid <input type="checkbox"/> Reduced hearing <input type="checkbox"/> Completely impaired <input type="checkbox"/> American Sign Language Vision: <input type="checkbox"/> Intact <input type="checkbox"/> Intact with visual aid <input type="checkbox"/> Visual field deficit <input type="checkbox"/> Double vision <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	To identify that patient may have special needs related to the swallowing deficit.	
Swallowing Assessment Completed: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes (If Yes, Include Prescription with Referral) <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Tube Type: _____ <input type="checkbox"/> 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: <input type="checkbox"/> Regular <input type="checkbox"/> Kosher <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal <input type="checkbox"/> Low Sodium <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: <input type="checkbox"/> home/community <input type="checkbox"/> hospital History & Frequency: <input type="checkbox"/> Frequent <input type="checkbox"/> Rare <input type="checkbox"/> 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): <input type="checkbox"/> Balance <input type="checkbox"/> Vision <input type="checkbox"/> Strength <input type="checkbox"/> Fatigue <input type="checkbox"/> Decreased insight/judgment <input type="checkbox"/> Unknown <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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.	Definition and Acronym
Dressing Type: _____ Frequency: _____ (e.g. Negative Pressure Wound Therapy or VAC)		Location: This is the location of the wound or ulcer on the patient body.
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes		Frequency and time to complete dressing is required to review impact on the patient's time to participate in the program.
<i>* If additional wounds exist, add supplementary information on a separate sheet of paper.</i>	Supplementary information can be part of the attachments included with the referral.	

Continance		
Data Field	Rationale for Requesting Information	Other
Is Patient Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If Yes, Skip to Next Section	Required for patient care planning.	
Bladder Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent		

Continance		
Data Field	Rationale for Requesting Information	Other
Bowel Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent Ostomy: <input type="checkbox"/> N/A <input type="checkbox"/> Yes Type/brand and care/products required _____ Ability to care for ostomy: <input type="checkbox"/> Independent <input type="checkbox"/> Total care <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	This information will provide the facility with the type of care needs required to support the patient.	
Medication Pump: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Methadone: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Epidural: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has a Pain Plan of Care Been Started: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> MMSE Score: _____ or <input type="checkbox"/> MoCA Score: _____		Folstein MF, Folstein SE, McHugh PR (1975). ""Minimal state". A practical method for grading the cognitive state of patients for the clinician". <i>Journal of Psychiatric Research</i> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Behaviour: <input type="checkbox"/> Need for Constant Observation <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Agitation <input type="checkbox"/> Wandering <input type="checkbox"/> Sundowning <input type="checkbox"/> Exit-Seeking <input type="checkbox"/> Resisting Care <input type="checkbox"/> Other <input type="checkbox"/> Restraints---If Yes, Type/Frequency Details: Level of Security: <input type="checkbox"/> Non-Secure Unit <input type="checkbox"/> Secure Unit <input type="checkbox"/> Wander Guard <input type="checkbox"/> One-to-one.		

Social History		
Data Field	Rationale for Information	Other
Discharge Destination: <input type="checkbox"/> Multi-Storey <input type="checkbox"/> Bungalow <input type="checkbox"/> Apartment <input type="checkbox"/> LTC <input type="checkbox"/> 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: <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Details Alcohol and/or Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Details	Helpful for determining care planning needs.	
Discharge Planning Post Hospitalization Addressed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> More Than 2 Hours Daily <input type="checkbox"/> 1-2 Hours Daily <input type="checkbox"/> Less Than 1 Hour Daily <input type="checkbox"/> 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: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist X1 <input type="checkbox"/> Assist X2 <input type="checkbox"/> 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: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist X1 <input type="checkbox"/> Assist X2 <input type="checkbox"/> 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: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> 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: <input type="checkbox"/> Full <input type="checkbox"/> As Tolerated Left: <input type="checkbox"/> U/E <input type="checkbox"/> L/E <input type="checkbox"/> Full <input type="checkbox"/> As Tolerated <input type="checkbox"/> Partial _____% <input type="checkbox"/> Toe Touch <input type="checkbox"/> Non: Date expected to be weight-bearing _____ <div style="text-align: right; color: gray; font-size: small;">DD/MM/YYYY</div>	<p style="text-align: center;">Definitions for Weight Bearing Status</p> 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: <input type="checkbox"/> U/E <input type="checkbox"/> L/E <input type="checkbox"/> Full <input type="checkbox"/> As Tolerated <input type="checkbox"/> Partial _____% <input type="checkbox"/> Toe Touch <input type="checkbox"/> Non: Date expected to be weight-bearing _____ <div style="text-align: right; color: gray; font-size: small;">DD/MM/YYYY</div>		
Limbs: <input type="checkbox"/> U/E impairment <input type="checkbox"/> L/E impairment <input type="checkbox"/> 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: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist X1 <input type="checkbox"/> 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	

Activities of Daily Living								
Data Field							Rationale for Requesting Information	Other
Describe Level of Function Prior to Hospital Admission (ADL & IADL)							To have an understanding of the patients premorbid level of functioning and a baseline to gauge the patient's progress.	Acronyms
Current Status Table-Complete the Table Below								IADL-Instrumental Activities of Daily Living
Activity	Independent	Cueing/ Set/Up or Supervision	Min. Assist	Mod. Assist	Max Assist	Total Care	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: <ul style="list-style-type: none"> Independent; Cueing/Setup or Supervision; Minimum Assist; Moderate Assist; Maximum Assist; Total Care. 	<i>Across the province sites are using either the RAI HC-ADL Self-Performance⁶; 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.</i>
Eating								
Grooming								
Dressing								
Dressing								
Toileting								
Bathing								

Special Equipment Needs						
Data Field		Rationale for Requesting Information		Other		
Special Equipment Required: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Skip to next Section		To ensure the receiving facility has the equipment and staff trained to support the patient's needs.				
<input type="checkbox"/> Halo <input type="checkbox"/> Orthosis <input type="checkbox"/> Bariatric <input type="checkbox"/> Other						
Pleuracentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No; Drain: : <input type="checkbox"/> Yes <input type="checkbox"/> No – if yes, please enter type/details						
Paracenteisis : <input type="checkbox"/> Yes <input type="checkbox"/> No; Drain: : <input type="checkbox"/> Yes <input type="checkbox"/> No – if yes, please enter type/details						
Need for Special Mattress: Yes/No						
Negative Pressure Wound Therapy: Yes/No						
<i>Rehabilitative Care Specific - AlphaFIM® Instrument</i>						
AlphaFIM® Data Available: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Skip to Next Section		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).		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.”		
Has the Patient Been Observed Walking 150 Feet or More: <input type="checkbox"/> Yes <input type="checkbox"/> No						
If Yes- Raw Ratings(rate levels 1-7):	Transfers: Bed, Chair				Expression	Transfers: Toilet
	Bowel Management				Locomotion: Walk	Memory
If No- Raw Ratings(rate levels 1-7):	Eating				Expression	Transfers: Toilet
	Bowel Management	Grooming	Memory			
Projected:	FIM® projected Raw Motor(13)	FIM® projected Cognitive (5)				
	Help Needed					

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: <input type="checkbox"/> Admission History and Physical <input type="checkbox"/> Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician) <input type="checkbox"/> All Relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US, etc.) <input type="checkbox"/> 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
<p>Functional Goal: <u>Progression</u> 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.</p> <p>Target Population: Medically stable, able to participate in comprehensive rehabilitation program</p> <p>Average LOS: <90 Days. Based on best practice targets and discharge indicator considerations. Rehab team to confirm LOS for specific program.</p> <p>Discharge Indicator: Rehab goals met, access to MD/nursing care no longer required</p> <p>Medical Care: Daily physician access</p> <p>Nursing Care: Up to 3 hrs/day. Some may go up to 4 hrs.</p> <p>Therapy Care: Direct care by regulated health professionals and as assigned to non-regulated professionals</p> <p>Therapy Intensity: 15-30 mins of therapy 3x/day to 3 hrs/day. Based on patient’s tolerance.</p>	<p>Functional Goal: <u>Progression</u> 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.</p> <p>Target Population: Medically stable, cognitively and physically able to participate in restorative activities</p> <p>Average LOS: (56-72 days) <90 Days</p> <p>Discharge Indicator: Rehab goals met, access to MD/nursing care no longer required</p> <p>Medical Care: Weekly physician access/follow-up</p> <p>Nursing Care: <2 hrs/day</p> <p>Therapy Care: Consulted by regulated health professionals, delivered mostly by non-regulated professional as assigned</p> <p>Therapy Intensity: Group or 1:1 setting, throughout the day 30 mins or up to 2 hrs/day (5-7 days/week).</p>	<p>Functional Goal: <u>Stabilization & Progression</u> Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.</p> <p>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.</p> <p>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</p> <p>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.</p> <p>Therapy Intensity: Up to 1 hr, as tolerated by the patient</p>	<p>Functional Goal: <u>Maintenance</u> Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function</p> <p>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</p> <p>Average LOS: Will remain at this level</p> <p>Discharge Indicator: Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes</p> <p>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.</p> <p>Therapy Intensity: Regulated health professional available to maintain and optimize functional abilities.</p>



700 Bay Street, Suite 601
Toronto, ON M5G 1Z6

Tel: 416-597-3057

Fax: 416-597-7021

Email: info@gtarehabnetwork.ca

www.gtarehabnetwork.ca