GTA REHAB Network

GTA Rehab Network Integrated Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form Updated with COVID-19 Fields

Insert Health Service Provider Logo	***Patient Identification***

Referral Destination

IDENTIFY REFERRAL DESTINATION:

Bedded Level of Rehabilitative Care

- ☐ *Rehabilitation – High Intensity*
- ☐ *Rehabilitation – Low Intensity*
- ☐ *Activation/Restoration – Hospital based/Other*
- ☐ ***Activation/Restoration – Convalescent Care (REFER THROUGH HOME & COMMUNITY CARE)***
- ☐ *Complex Medical Management- Short Term*
- ☐ *Complex Medical Management- Long Term*

Complex Continuing Care (CCC)

☐ *Other programs (specify):*

_____

If Faxed Include Number of Pages (Including Cover):

_____ **Pages**

Estimated Date of Rehabilitative Care/CCC Readiness: DD/MM/YYYY

Patient Details and Demographics

Health Card #: Version Code: Province Issuing Health Card:

No Health Card #: ☐ No Version Code: ☐

Surname: Given Name(s):

No Known Address: ☐

Home Address: City: Province:

Postal Code: Country: Telephone: Alternate Telephone:

No Alternate Telephone: ☐

Current Place of Residence (Complete If Different From Home Address):

Date of Birth: DD/MM/YYYY Gender: ☐ M ☐ F ☐ Other_____ Marital Status:

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ Other _____

Primary Alternate Contact Person:

Relationship to Patient (Please Check All Applicable Boxes): ☐ POA ☐ SDM ☐ Spouse ☐ Other_____

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Insert Health Service Provider Logo	***Patient Identification***

Secondary Alternate Contact Person: None Provided: ☐

Relationship to Patient: ☐ POA ☐ SDM ☐ Spouse ☐ Other _____ (Please Check All Applicable Boxes)

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Responsibility for Payment:

Insurance: _____ N/A: ☐

☐ OHIP ☐ Federal Government ☐ IFH (Interim Federal Health Grant)
☐ Inter-provincial Insurance Plan ☐ Insured/Self Pay ☐ Other Payment Sources
☐ WSIB ☐ Uninsured/Self Pay ☐ Unknown

Preferred accommodation:
☐ Ward ☐ Semi private ☐ Private ☐ Other (specify): _____

For CCC Only - Co-Payment Discussed With: ☐ Patient ☐ Other_____

Rehabilitative Care/CCC Population Requested:

☐ ABI ☐ Amputee ☐ Burns ☐ Cardiac ☐ Chronic Ventilation ☐ General/Medical
☐ Geriatric ☐ MSK ☐ Neuro ☐ Oncology ☐ Respiratory Rehab ☐ Spinal Cord
☐ Stroke ☐ Trauma ☐ Transplant ☐ Other _____

Current Location Name: Current Location Address:

City: Province: Postal Code:

Current Location Contact Number: Bed Offer Contact Name: Bed Offer Contact Number:

Medical Information

Primary Health Care Provider (e.g. MD or NP) ☐ None

Surname: Given Name(s):

Allergies: ☐ No Known Allergies ☐ Yes --- If Yes, List Allergies:

Infection Control: ☐ None

☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ COVID-19 (Specify details on next page) ☐ Other (Specify)

Insert Health Service Provider Logo	***Patient Identification***

COVID-19: Date of symptom onset/diagnosis: _____ DD/MM/YYYY List of symptoms:	1st Test: _____ DD/MM/YYYY 1st Test Result: _____ 2nd Test: _____ DD/MM/YYYY 2nd Test Result: _____

Admission Date: DD/MM/YYYY Date of Injury/Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Nature/Type of Injury/Event:

Primary Diagnosis:

Current Medical Issues:

Past Medical History:

Attach the following:
Medication: ☐ MAR
Lab Work: ☐ If indicated, send most recent lab work (e.g. Haemoglobin, white blood cell count, lytes, creatinine)

Height: Weight:

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_____

Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No Frequency: _____ Duration:_____

Location: _____

Insert Health Service Provider Logo	***Patient Identification***

Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No Frequency: _____ Duration:_____

Location:_____

Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ No Details:

Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative Palliative Performance Scale:_____ ☐ Unknown

Advanced Medical Directives:

Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other_____

Pending Investigations: ☐ Yes ☐ No Details:

Frequency of Lab Tests: _____ Unknown:☐ None: ☐

Study Medications: ☐ Yes ☐ No Details:

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements? ☐ Yes ☐ No -- If No, Skip to Next Section

Was the patient intubated as part of their care?" ☐ Yes Number of days _____ ☐ No

Supplemental Oxygen: ☐ Yes ☐ No Ventilator: ☐ Yes ☐ No Chest Tube: ☐ Yes ☐ No

☐ Target 02 Sat _____ % ☐ Intermittent Oxygen _____ L/min ☐ Constant Oxygen _____L/min

☐ 02 at rest _____ L/min ☐ 02 at exercise_____ L/min

Special Oxygen Equipment/Human Resources required? (e.g. rebreather, Optiflow, specialized resources of Respiratory Therapist):

☐ No ☐ Yes (if Yes, please specify): _____

Breath Stacking: ☐ Yes ☐ No Insufflation/Exsufflation: ☐ Yes ☐ No

Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless Type: Size:

Suctioning: ☐ Yes ☐ No Frequency:

C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

Insert Health Service Provider Logo	***Patient Identification***

Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

Additional Comments:

IV Therapy

IV in Use? ☐ Yes ☐ No -- If No, Skip to Next Section

IV Therapy: ☐ Yes ☐ No Central Line: ☐ Yes ☐ No PICC Line : ☐ Yes ☐ No

Name of IV Medication:

Hearing/Vision

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

Swallowing and Nutrition

Swallowing Deficit: ☐ Yes ☐ No Swallowing Assessment Completed?: ☐ Yes ☐ No

Type of Swallowing Deficit Including any Additional Details:

TPN: ☐ Yes (If Yes, Include Prescription With Referral) ☐ No

Enteral Feeding: ☐ Yes ☐ No ☐ Tube Type: _____ ☐ Specify Formula Type & Rate of Feeds: _____

Therapeutic Diet Type: ☐ Regular ☐ Kosher ☐ Diabetic ☐ Renal ☐ Low Sodium ☐ Other (specify): _____

Diet Texture: ☐ Regular ☐ Other (specify): _____

Falls

Does Patient Have a History of Falls? ☐ Yes ☐ No -- If No, Skip to Next Section

Insert Health Service Provider Logo	***Patient Identification***

If yes, specify: ☐ home/community ☐ hospital

History & Frequency: ☐ Frequent ☐ Rare ☐ Intermittent

Reason for most recent fall(s):

☐ Balance ☐ Vision ☐ Strength ☐ Fatigue ☐ Decreased insight/judgment ☐ Unknown

☐ Other (list):

Skin Condition

Surgical Wounds and/or Other Wounds Ulcers? ☐ Yes ☐ No -- If No, Skip to Next Section

1. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes	
2. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes	
3. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
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.***

Continence

Is Patient Continent? ☐ Yes ☐ No -- If Yes, Skip to Next Section

Bladder Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

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

Insert Health Service Provider Logo	***Patient Identification***

Pain Care Requirements

Does the Patient Have a Pain Management Strategy? ☐ Yes ☐ No -- If No, Skip to Next Section

Controlled With Oral Analgesics:	☐ Yes ☐ No
Medication Pump:	☐ Yes ☐ No
Methadone:	☐ Yes ☐ No
Epidural:	☐ Yes ☐ No
Has a Pain Plan of Care Been Started?	☐ Yes ☐ No

Communication

Does the Patient Have a Communication Impairment? ☐ Yes ☐ No -- If No, Skip to Next Section

Communication Impairment Description:

Cognition

Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess -- If No or Unable to Assess, Skip to Next Section

Details on Cognitive Deficits:

Has the Patient Shown the Ability to Learn and Retain Information: ☐ Yes ☐ No -- If No, Details: _____

Cognitive Status (Complete Table Below)	**Not Tested**	**Intact**	**Impaired**
Orientation	☐	☐	☐ *(specify):*
Attention	☐	☐	☐ *(specify):*
Able to follow instructions	☐	☐	☐ *(specify):*
Memory (short term)	☐	☐	☐ *(specify):*

Insert Health Service Provider Logo	***Patient Identification***

Memory (long term)	☐	☐	☐ *(specify):*
Judgment	☐	☐	☐ *(specify):*
Insight	☐	☐	☐ *(specify):*
Frustration Tolerance (ABI only)	☐	☐	☐ *(specify):*
Other	☐	☐	☐ *(specify):*
☐ MMSE Score: _____ *or* ☐ MoCA Score: _____	☐	If did not/unable to complete, please explain:	

Rancho Los Amigos Cognitive Scale at present: (ABI only): _____

Delirium: ☐ Yes ☐ No -- If Yes, Cause/Details: _____

History of Diagnosed Dementia: ☐ Yes ☐ No

Behaviour

Are There Behavioural Issues? ☐ Yes ☐ No -- If No, Skip to Next Section

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

Discharge Destination: ☐ Multi-Storey ☐ Bungalow ☐ Apartment ☐ LTC
☐ Retirement Home (Name):

Accommodation Barriers: ☐ Unknown

Smoking: ☐ Yes ☐ No Details:

Alcohol and/or Drug Use: ☐ Yes ☐ No Details:

Insert Health Service Provider Logo	***Patient Identification***

Previous Community Supports: ☐ Yes ☐ No Details:

Discharge Planning Post Hospitalization Addressed: ☐ Yes ☐ No Details:

Discharge Plan Discussed With Patient/SDM: ☐ Yes ☐ No

Current Functional Status

Patient Goals (Please Indicate Specific, Measurable Goals):

Participation Level:
(Specify): On average, patient is able to participate in _____ therapy sessions / day, _____times / week for _____minutes / session

Sitting Tolerance: ☐ More Than 2 Hours Daily ☐ 1-2 Hours Daily ☐ Less Than 1 Hour Daily ☐ Has not Been Up

Transfers: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Mechanical Lift

Ambulation: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Unable

Number of Metres: _____

Stairs: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Stair Lift/Glider

Weight Bearing Status:
Left: ☐ U/E ☐ L/E

☐ Full ☐ As Tolerated ☐ Partial _____% ☐ Toe Touch ☐ Non Date expected to be weight-bearing _____
DD/MM/YYYY

Right: ☐ U/E ☐ L/E

☐ Full ☐ As Tolerated ☐ Partial _____% ☐ Toe Touch ☐ Non Date expected to be weight-bearing _____

Insert Health Service Provider Logo	***Patient Identification***

Limbs:
Left: ☐ U/E impairment ☐ L/E impairment ☐ Aid(s) Required: _____
Right: ☐ U/E impairment ☐ L/E impairment ☐ Aid(s) Required: _____

Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2

Activities of Daily Living

Describe Level of Function Prior to Hospital Admission (ADL & IADL):

Current Status – Complete the Table Below:

Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Eating: (Ability to feed self)						
Grooming: (Ability to wash face/hands, comb hair, brush teeth)						
Dressing: (Upper body)						
Dressing: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						

Insert Health Service Provider Logo	***Patient Identification***

Special Equipment Needs

Special Equipment Required? ☐ Yes ☐ No -- If No, Skip to Next Section

☐ HALO ☐ Orthosis (including splints, slings)

☐ Bariatric - If Yes, Please Describe Equipment Needs:_____

☐ Other:

Pleuracentesis: ☐ Yes ☐ No Drain: ☐ Yes ☐ No - If Yes, Type Details:_____

Paracentesis: ☐ Yes ☐ No Drain: ☐ Yes ☐ No - If Yes, Type Details:_____

Need for a Specialized Mattress: ☐ Yes ☐ No Negative Pressure Wound Therapy (NPWT): ☐ Yes ☐ No

Rehabilitative Care Specific **AlphaFIM® Instrument**

Is AlphaFIM® Data Available: ☐ Yes ☐ No -- If No, Skip to Next Section

Has the Patient Been Observed Walking 150 Feet or More: ☐ Yes ☐ No

If Yes –Raw Ratings (rate levels 1-7)	Transfer: 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:		

Insert Health Service Provider Logo	*Patient Identification*

Attachments

Details on Other Relevant Information That Would Assist With This Referral:

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)

Completed By: **Title:** **Date:** DD/MM/YYYY

Contact Number: **Direct Unit Phone Number:**