GTA Rehab Network Integrated Acute Care to
Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC) Referral Form

This referral form is in compliance with the Provincial Referral Standards and includes supplemental information for referral to bedded Rehabilitative Care programs in the GTA.

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: ☐

GTA REHAB Network

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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) Surname: Given Name(s):

☐ None

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

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify):_____

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

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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: _____

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

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

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

Supplemental Oxygen: ☐ Yes ☐ No Ventilator: ☐ 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

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

Additional Comments:

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

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: _____

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

Falls

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

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):

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

Skin Condition

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

1. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

2. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

3. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

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

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

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

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):*
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:	

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

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:

Previous Community Supports: ☐ Yes ☐ No Details:

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

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

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

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 _____

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):

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

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)						

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

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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:		

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:**