GTA REHAB Network

**SUPPLEMENTAL REFERRAL INFORMATION FORM**
**Referrals from Acute Care to**
**Bedded Levels of Rehabilitative Care & Complex Continuing Care (CCC)**

The information within this form supplements the referral information in *Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care* for referrals from acute care to inpatient rehab & CCC. Use this form is to provide updates on patients who have already been referred. (Note: Not used for stroke patients.)

Bradma/Addressograph

## CONTACT INFORMATION

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

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

## MEDICAL INFORMATION

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

☐ COVID-19 (Specify details below)

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

**Attach the following:**

Medication: ☐ MAR

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

**Dialysis:** ☐ N/A

**If Dialysis Centre is located off-site from rehab/CCC, indicate how patient will access Dialysis Centre:**

☐ Family drives ☐ Volunteer drives ☐ Wheel-Trans ☐ Other_____

## CARE REQUIREMENTS

**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

**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

**Diet:**

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

If yes, specify: ☐ home/community ☐ hospital

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History & Frequency: ☐ Frequent ☐ Rare ☐ Intermittent

Reason for most recent fall(s):
☐ Balance ☐ Vision ☐ Strength ☐ Fatigue ☐ Decreased insight/judgment ☐ Unknown
☐ Other (list):

**Ostomy:** ☐ N/A ☐ Yes **Type/brand and care/products required** _____

Ability to care for ostomy: ☐ Independent ☐ Total care ☐ Requires supervision

## COGNITION

| **Cognitive Status:** | Not Tested | Intact | Impaired |
|---|---|---|---|
| Orientation (ABI only) | ☐ | ☐ | ☐ *(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: | |

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

## CURRENT FUNCTIONAL STATUS

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