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

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:

☐ 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:

☐ 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):

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

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

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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.