Toronto Stroke Rehab Referral System

ACUTE CARE TO OUTPATIENT REHAB REFERRAL FORM

OUTPATIENT STROKE REHABILITATION REFERRALS:

Please complete all fields and send referral electronically through **E-Stroke**

(for programs outside of Toronto, fax a copy of this form to the stroke rehab program)

NOTE: Referrals to community programs require the ATTENDING physician's name and phone number.

1. PATIENT REGISTRATION

Patient's First Name	**Last Name**	
Patient's gender ☐ M ☐ F	**Patient's DOB**	**YYYY-MM-DD**
Health Card Number *	**Version**	**Expiry Date**
Province/Territory Issuing Health Card	**Referral Provider**	

2. DEMOGRAPHICS

Patient's Home Address

Postal Code

Home Telephone Number | **Alternate Contact Phone Number**

Family Physician's name *

Family Physician's contact information (phone or fax) *

Primary language spoken

Speaks, understands English ☐ Yes ☐ No ☐ Minimal | Interpreter Needed? ☐ Yes ☐ No

Speaks, understands another language (list)

Premorbid Vocational Status (before this encounter) (amended from CIHI-NRS)

☐ Full time or 30 hrs/week ☐ Part-time <30 hrs/week ☐ Adjusted/modified work ☐ Student ☐ Volunteer

☐ Retired ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Don't know

Type of vocation

Educational Level (choose HIGHEST level completed)

☐ High School Grade 12 ☐ High School Grade 13 ☐ College Diploma ☐ University Degree

☐ Masters Degree ☐ Doctoral Degree ☐ Don't know ☐ Other (list)

* Electronic Referral cannot be made without completion of this field

3. ACUTE CARE MEDICAL ASSESSMENT: STROKE EVENT

Dear Physician or Physician Designate,
You have been asked, to complete this Medical Assessment.
***All fields must be completed.**

Patient's Name:

Date of Stroke Onset (or last seen normal) * **YYYY-MM-DD**

First Stroke? * ☐ **Yes** ☐ **No**	**Date Previous Stroke** **YYYY-MM-DD**
Deficits Previous Stroke	
Type of Stroke * *(current stroke)*	☐ Ischemic ☐ Hemorrhagic ☐ Transforming to Hemorrhagic
Stroke Location *(most recent CT/MRI)*	☐ Left ☐ Right ☐ Frontal ☐ Parietal ☐ Occipital ☐ Temporal ☐ Internal Capsule ☐ Basal ganglia ☐ Thalamus ☐ Cerebellum ☐ Brainstem
Mechanism of Stroke	☐ Carotid Stenosis Required Surgery? ☐ Yes ☐ No ☐ Cardioembolic ☐ Atrial Fibrillation ☐ Dilated Cardiomyopathy or other structural/wall movement abnormality ☐ Valvular problem ☐ Dissection ☐ Carotid ☐ Vertebral ☐ Small Vessel Thrombosis ☐ Auto Immune ☐ Unknown ☐ Other (Provide details) ....

Deficits Current Stroke

☐ L Hemiparesis ☐ R Hemiparesis ☐ No Paresis ☐ Aphasia
☐ Dysphagia ☐ Apraxia ☐ Sensory Neglect ☐ Ataxia
☐ Other (provide details): ....

Old/Chronic CT or MRI Findings	☐ None ☐ Evidence of previous infarcts ☐ Sub cortical white matter changes - Mild ☐ Sub cortical white matter changes - Moderate ☐ Sub cortical white matter changes - Severe

Stroke Workup

Echocardiogram	**Holter Monitor**	**Carotid Imaging**	**Secondary Prevention Clinic**
☐ Done	☐ Done	☐ Done	☐ Booked ____/__/__ yyyy/mm/dd
☐ Not indicated	☐ Not indicated	☐ Not indicated	☐ Referred
☐ Booked ____/__/__ yy/mm/dd	☐ Booked ____/__/__ yy/mm/dd	☐ Booked ____/__/__ yy/mm/dd	☐ Not Required

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3. ACUTE CARE MEDICAL ASSESSMENT: STROKE EVENT (cont)

Patients Name:

Specific conditions impacting on rehab potential

- ☐ **None on this list**
- ☐ Angina
- ☐ Coronary Artery bypass Surgery or Stenting procedure
- ☐ Atrial Fibrillation
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Amputation
- ☐ Asthma
- ☐ Systemic Lupus Erythematosis
- ☐ Cerebral Vasculitis
- ☐ Other (list): ....

Charleson Comorbidities Index

☐ No comorbidities on **THIS** list

- ☐(1) Myocardial Infarct
- ☐(1) Congestive Heart failure
- ☐(1) Peripheral Vascular disease
- ☐(1) Cerebrovascular disease
- ☐(1) Dementia
- ☐(1) Chronic pulmonary disease
- ☐(1) Connective tissue disease
- ☐(1) Ulcer
- ☐(1) Mild liver disease
- ☐(1) Diabetes
- ☐(2) Hemiplegia (Pre-existing)
- ☐(2) Moderate or severe renal disease
- ☐(2) Diabetes with end organ damage
- ☐(2) Any tumor
- ☐(2) Leukemia
- ☐(2) Lymphoma
- ☐(3) Moderate or severe liver disease
- ☐(3) AIDS

The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores > 3 may not tolerate rehabilitation

☐ **Other Comorbid Conditions of Significance** (list): ....

Previous psychiatric history * **No** ☐ **Yes** ☐ **If Yes describe history and status**

....

Current psychiatric diagnosis * **No** ☐ **Yes** ☐ **if Yes specify diagnosis and status**

....

Attending Physician's Name *
(most responsible physician for billing purposes; full name required)

Phone Number*:

Referring Physician Name

Date YYYY-MM-DD

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4. EPISODE INFORMATION

Patient's Name	**MRN/Chart Number**
Patient's admission date	**YYYY-MM-DD**
Patient's discharge date	**YYYY-MM-DD**
FINANCES	
Who manages the patient's FINANCES now? ☐ Self ☐ Others	☐ Don't Know
If OTHERS, list contact information contact person, FINANCES **Name** **Relationship to patient** ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other	
Address	Postal Code
Daytime Phone	Evening Phone
PERSONAL CARE	
Who manages the patient's PERSONAL CARE decisions now? ☐ Self ☐ Others	
If others, list contact information ☐Same as contact person, **FINANCES OR**	
Contact Person, PERSONAL CARE decisions **Name** **Relationship to patient** ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other	
Address	Postal Code
Daytime Phone	Evening Phone
SUBSTITUTE DECISION MAKER	
Document if patient retains any of the following ☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian	☐ Public Guardian/Trustee ☐ N/A
Contact information if applicable ☐Same -Contact, FINANCES ☐ Same-Contact, PERSONAL CARE	☐ Other, see below.
If OTHER list contact information **Name** **Relationship to patient** ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other	
Address	Postal Code
Daytime Phone	Evening Phone

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4. EPISODE INFORMATION (cont)

Patients name

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Common Law
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

Home living situation, living with: (Adapted from CIHI-NRS)

- ☐ Spouse/partner
- ☐ Family (including extended family)
- ☐ Others
- ☐ Living alone
- ☐ Not applicable
- ☐ Unknown

Caregiver support can be provided by:

- ☐ Spouse/partner
- ☐ Family (including extended family)
- ☐ Roommate or Others
- ☐ NA

Previous additional Support required:

- ☐ Attendant care
- ☐ Home support
- ☐ Privately-funded care
- ☐ None

If additional support, describe:

Can caregiver currently provide support with:

☐ **N/A**, patient does not have a caregiver

	ADL	IADL
Willing	☐	☐
Able	☐	☐
Available days	☐	☐
Available evenings	☐	☐

Comments caregiver support:

Present accommodation:

- ☐ House
- ☐ Residential group home
- ☐ Apartment Building
- ☐ Rooming house
- ☐ Unknown
- ☐ Homeless
- ☐ Other (list):

Expected Discharge Destination: *

- ☐ Home
- ☐ Home, CCAC +/- paid help
- ☐ Assisted Living (seniors apt building, retirement home)
- ☐ LTC/CCC
- ☐ Shelter/Hostel

Completed by:	**Date:** **YYYY-MM-DD**

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6. REHAB ASSESSMENT: ALPHAFIM® INSTRUMENT

PT/OT to complete

Patient's Name:		**Date of Birth:**	**YYYY-MM-DD**
Tester Name:		**Date of Assessment:**	**YYYY-MM-DD**

Type of Stroke: (tick one)
☐Stroke R body ☐Stroke L body ☐Stroke no paresis ☐Stroke bilateral ☐Other stroke

Complete the AlphaFIM® Instrument items indicated below based on the distance the patient can currently walk.

Patient walks less than 150ft		Patient walks 150ft or more	
Eating		Transfers: Bed Chair	
Grooming		Walk	
Bowe Management		Bowel Management	
Transfers: Toilet		Transfers: Toilet	
Expression		Expression	
Memory		Memory	

Note: leave no blanks
enter 1 if not able to test an item due to risk

AlphaFIM® Instrument Rating Levels

No HELPER

7. Complete Independence (no device, timely, safely)

6. Modified Independence (device, not timely, or not safely)

Helper

Modified Dependence (performs 50% or more of task)

5. Supervision (patient performs 100% of the effort)

4. Minimal Assistance (patient performs 75% or more of the effort)

3. Moderate Assistance (patient performs 50% - 74% of the effort)

Complete Dependence (performs less than 50% of task)

2. Maximal Assistance (patient performs 25% - 49% of the effort)

1. Total Assistance (patient performs < 25% of the effort)

Comments:

Projected Scores from AlphaFIM® Instrument software at www.udsmr.org (select software portal, AlphaFIM® software).

FIM® 13 Raw Motor	
FIM® 5 Raw Cognition	
FIM® 13 Rasch Motor	
FIM® 5 Rasch Cognition	
FIM® Motor Range	
FIM® Cognition Range	
FIM® Walking Range	
Help Needed	

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6. ABILITIES AND TOLERANCE: ORPINGTON PROGNOSTIC SCALE

PT/OT to complete

Patient's Name	Date YYYY-MM-DD
Tester's Name	Phone YYYY-MM-DD

Orpington Prognostic Scale: Grade the patient by CIRCLING the appropriate scores below.

Motor deficit in arm Lying supine, patient flexes shoulder to 90 degrees and is given resistance	
MRC grade 5 (normal power)	0
MRC grade 4 (diminished power)	0.4
MRC grade 3 (movement against gravity)	0.8
MRC grade 1-2 (movement with gravity eliminated or trace)	1.2
MRC grade 0 (no movement)	1.6
Proprioception (eyes closed) Locates affected thumb	
Accurately	0
Slight difficulty	0.4
Finds thumb via arm	0.8
Unable to find thumb	1.2
Balance	
Walks 10 feet without help	0
Maintains standing position	0.4
Maintains sitting position	0.8
No sitting balance	1.2
Cognition (Hodgkins Mental test): Can the patient recall…….	
1. Age of the patient	1
2. Time (to the nearest hour)	1
(Prompt by you) I am going to give you an address, please remember it and I will ask you later: 42 West St	
3. Name of hospital	1
4. Year	1
5. Date of birth of patient	1
6. Month	1
7. Years of Second World War (1939-1945) (approximate range okay)	1
8. Name of President of the United States	1
9. Count backwards from 20	1
10. What is the address I asked you to remember?	1

Total Orpington Prognostic Score

1.6
+
Motor score
+
Proprioception
+
Balance score
+
Cognition Score

= ___________

Scoring Cognition (Score out of 10)

Mental score 10 = **0.0**
Mental score 8-9 = **0.4**
Mental score 5-7 = **0.8**
Mental score 0-4 = **1.2**

Interpretation of Stroke Severity Score

< 3.2 score = **3 minor stroke**
3.2-5.2 score = **1 moderate stroke**
> 5.2 score = **-1 major stroke**

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6. ABILITIES AND TOLERANCE: ORPINGTON MODIFIERS

PT/OT to complete

Patient's name:

Stroke Modifiers	**-1** ☐	Coma at onset of stroke
	+1 ☐	Pure motor deficit
	-1 ☐	Visuospatial deficit (*draw a clock face with the time of 10 minutes after 11 am, OR if the patient cannot draw, have patient observe a clock and tell the time, or complete line bisection test)
	+1 ☐	Lacunar infarct
	-2 ☐	Bihemispheric deficit
	-1 ☐	Dysphagia
	-2 ☐	Parietal Symptoms
	-1 ☐	Incontinence persists 2 weeks or longer post stroke
Patient Modifiers	**+2** ☐	Age <55 years
	-3 ☐	*Severe cardiovascular disease* CCS Class III-IV and/or NYHA Class III-IV Angina
	-3 ☐	*Severe respiratory disease* Dyspnea Class III-IV
	-1 ☐	Coexistent symptomatic PVD
	-1 ☐	Poor Premorbid functioning
Time Modifiers	**+2** ☐	Time elapse since stroke < 2 weeks
	0 ☐	Time elapsed since stroke = 2-4 weeks
	-1 ☐	Time elapsed since stroke = 4-8 weeks
	-2 ☐	Time elapsed since stroke > 8 weeks

Modified Orpington Score (Sum of modifiers PLUS stroke severity score from previous page) ....

If final score is =≥ 0 Client is a candidate for active IP rehab programs or home rehab.
If final score is < 0 Client is a candidate for low tolerance rehabilitation programs

Or ☐ Unable to complete Orpington due to Aphasia
☐ Unable to complete Orpington due to other (list) ....

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6. ABILITIES AND TOLERANCE: FUNCTION

PT/OT to complete

Patient's Name:	**Date:** **YYYY-MM-DD**
Completed by:	**Phone Number:**

Comment on changes in patient's PROGRESS (functional gains) in the past week and implications for future rehab:

Ability to participate:

Physical Activity tolerance *
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ > 1 hour

Sitting tolerance *
- ☐ **Supported**
- ☐ **Unsupported**
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >1 hour

Mental Activity Tolerance *
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >1 hour

Frequency of therapy treatment tolerated: ☐ Daily ☐ 2-3 x per week ☐ Weekly

Comment on changes in PARTICIPATION in last week and implications for future rehab:

Motivation to participate in rehabilitation (tick ALL that apply)
- ☐ Demonstrates motivation to participate in rehab (regular attendance and involvement, cooperation)
- ☐ Usually motivated to participate, occasional frustration apparent
- ☐ Motivated to participate but attendance, involvement or cooperation irregular

Is the patient experiencing shoulder pain? ☐ **Yes** ☐ **No**

Comment:

Can patient take direction, retain and execute verbal OR written OR visual instructions? ☐ **Yes** ☐ **No**

Anticipated Progress: √ the column matching anticipated independence by end of next rehab setting	**Independent with or without aids**	**Minimal assistance**	**Moderate to maximal assistance**
Locomotion			
Transfers			
ADL			
Other (list)			

Additional services:
- ☐ Pain management
- ☐ Self care & mobility assessment prescription

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6. ABILITIES AND TOLERANCE - SPEECH

SLP to complete

Patient's Name	**Date** YYYY-MM-DD
Tester:	**Tester Phone**

Communication Disorder	**Speech**	**Communicates**
☐ None ☐ New ☐ Old ☐ Both new and old	☐ Adequate ☐ Receptive aphasia ☐ Expressive aphasia ☐ Dysarthria ☐ Apraxia	☐ Adequately ☐ With Difficulty ☐ Unable

Changes in COMMUNICATION status in past week and implications for future rehab:

Swallowing Disorder *	**Phase swallowing affected**	**Has videofluoroscopy been performed on this admission?**
☐ None ☐ New ☐ Old ☐ Both new and old	☐ Pharyngeal ☐ Oral ☐ Both	☐ Yes ☐ No **Repeat/videoflouroscopy recommended?** ☐ Yes ☐ No

Changes in SWALLOWING status in last week and implications for future rehab:

Diet *	**Adjusted diet: solids**	**Adjusted diet: liquids**
☐ Regular ☐ NPO ☐ PEG ☐ NG	☐ Minced diet ☐ Pureed diet ☐ Dental soft diet ☐ Snacks only ☐ Other (list below):	☐ Thin liquids ☐ Nectar thick liquids ☐ Honey thick liquids ☐ Pudding ☐ Sips of water only ☐ G-tube feeds ☐ Other (list below):

Changes in DIET in past week and implications for future rehab:

Anticipated Progress: √ the column matching anticipated level of independence by end of next rehab setting	**Independent with or without aids**	**Minimal assistance**	**Moderate to maximal assistance**
Communication			
Feeding			

Impact of communication disorder(s) on behaviour
☐ None
☐ Mild
☐ Moderate
☐ Severe

Speech, language and diet comments:

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6. COGNITION AND BEHAVIOUR ASSESSMENT

Patient's Name	**Date** YYYY-MM-DD
Tester	**Phone**

Perceptual status
- ☐ Normal
- ☐ Mild Inattention
- ☐ Moderate Inattention
- ☐ Severe Inattention
- ☐ Body neglect
- ☐ Reduced depth perception
- ☐ Affected spatial awareness/skills
- ☐ Apraxia

Attention	**Memory ***	**Judgment ***	**Executive Functioning ***
☐ No deficit	☐ No deficit	☐ No deficit	☐ No deficit
☐ Mild	☐ Mild	☐ Mild	☐ Mild
☐ Moderate	☐ Moderate	☐ Moderate	☐ Moderate
☐ Severe	☐ Severe	☐ Severe	☐ Severe
☐ Unable to test	☐ Unable to test	☐ Unable to test	☐ Unable to test

MoCA Score _______/30 (MoCA is a cognitive screening tool. A score <26 warrants ongoing cognitive assessment)

Comments on COGNITION

In your opinion, rate the patient's progress in the past week
- ☐ Marked progress in the past week
- ☐ Moderate progress in the past week
- ☐ Minimal progress in the past week
- ☐ Patient has plateaued in progress in the past week
- ☐ Patient is too acute to measure progress in the past week
- ☐ Other (comment)

Comment, RATE OF PROGRESS

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7. STROKE REFERRAL

Patients Name	
Primary contact for information	
Your organization and/or program name	
Bed offer contact name and number/pager*	
Date referral completed	**YYYY-MM-DD**
Anticipated date ready for rehab[1]	**YYYY-MM-DD**
Comments, ready for rehab status	
Choose whether initial referral or update ☐ Initial referral ☐ Update (responding to intake need for more information)	**Rehab setting type** ☐ Outpatient Rehab
Planned referral destination **1.**	

Reason for referral – services, programs and transportation (check ALL that apply)

☐Behavioural rehab
☐Caregiver peer support
☐Case management
☐Clinical dietitian
☐Life skills training
☐Long term living
☐Medical specialist
☐Nursing
☐Occupational therapy
☐Vocational rehab
☐Restore continence
☐Self care & mobility assessment prescription
☐Restore avocation
☐Physiatry
☐Physical therapy
☐Psychology
☐Recreational day program
☐Respite care
☐Social work
☐Speech language pathology
☐Supportive independent living
☐Transitional living
☐Pain Management
☐Manage Depression
☐Home management skills
☐Other (list)____________

Transportation (check ALL that apply)

☐Independent
☐Accompanied by friend/family
☐Accompanied by attendant
☐Uses Wheel Trans
☐Uses other (list)____________________
☐Uses public transport

[1] Ready for rehab: Refer to Inpatient Rehab Referral Guidelines GTA Rehab Network 2005

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