South East (SE)Rehabilitation/Complex Care (C/、

Cluster 3 (Acute to Rehab) Referral Form - Introduction

This referral form is in compliance with the Provinicial Referral Standards

This form is designed to be filled out electronically, then emailed or printed and faxed to the facility you have chosen.

However, the option of printing out the blank form and filing it out by hand does exist. If when filling the form out by hand you determine that there is not enough room on the form for you to elaborate, please include your further information on another sheet of paper at the end of the referral form.

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Note: If you are including additional pages to this form, remember to include the surname, first name and date of birth (D.O.B) up in the top right hand corner and number the pages to show the total number of pages to be received in the package.

Referral from KGH Unit: ONLY KGH: Please complete and send electronically to servicereferrals@providencecare.ca (ProvCare, Inpatient Service Referrals)

FOR ALL OTHER REFERRAL SOURCES: Please Fax to Providence Care Hospital Central Intake 613-548-5595

Please attach the following with this referral:
MAR
Relevant Interprofessional Assessments/Progress Notes

Rehabilitation Criteria (all boxes must be checked to proceed with the application)

☐ The patient must have a physical impairment requiring rehabilitation **OR** have a known cognitive and/or communication impairment requiring ongoing rehabilitation support or services.

☐ The patient is medically stable:

- A clear diagnosis and co-morbidities have been established.
- At the time of discharge from acute care, acute medical issues have been addressed: disease processes and/or impairments are not precluding participation in rehabilitation program.
- Patient's vital signs are stable.
- No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).
- Medication needs have been determined.

☐ The patient or a substitute decision-maker must willingly consent to participate in a rehabilitation program.

☐ The patient must have the cognitive ability to participate in and benefit from a rehabilitation program.

☐ The patient or a substitute decision-maker and medical team have identified realistic, specific, measureable and timely, functional goals for the rehabilitation process.

REHAB
- ☐ CVA (Cerebrovascular Accident (Stroke))
- ☐ ABI (Acquired Brain Injury)
- ☐ SCI (Spinal Cord Injury)
- ☐ MSK (Musculoskeletal)

COMPLEX CARE
- ☐ RR (Restorative Rehabilitation)
- ☐ SR (Seniors Rehabilitation)
- ☐ CM (Complex Medical)

Surname:
First Name:
D.O.B.:

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Cluster 3 Acute Care to Rehab & Complex Care (CC) Referral

Identify Referral Destination: ☐ *Referral to Rehab*

☐ *Referral to Complex Continuing Care (CCC)*

If Faxed Include Number of Pages (Including Cover):

Estimated Date of Rehab/CCC Readiness (DD/MM/YYYY):			
Patient Details and Demographics			
Health Card #:	Version Code:	No Health Card #: ☐	No Version: ☐
Province Issuing Health Card: ON		Code: ☐	
Surname:		Given Name(s):	
No Known Address: ☐			
Home Address:		City:	Province: ON
Postal Code:	Telephone #:		Cell #:
Country:		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: Select
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 #:	Cell #:	No Alternate Telephone #: ☐	
Secondary Alternate Contact Person:		None Provided: ☐	
Relationship to Patient(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other _____			
Telephone #:	Cell #:	No Alternate Telephone #: ☐	
Insurance Company:		N/A: ☐	
Current Location Name (referring source):			
City:			
Current Location Address:			
Province: ON	Postal Code:		
Current Location Contact Number:		Bed Offer Contact Number:	
Bed Offer Contact (Name):			

Surname:	Office Use Only
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D.O.B.:	

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Medical Information		
Primary Health Care Provider (e.g. MD or NP) Surname:	Given Name(s):	
☐ Do Not Have A Primary Health Care Provider		
Reason for Referral:		
Allergies: ☐ No Known Allergies ☐ Yes I have Allergies	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:
Rehab Specific Patient Goals:		
CCC Specific Patient Goals:		
Nature/Type of Injury/Event:		
Primary Diagnosis:		
History of Presenting Illness/Course in Hospital:		
Current Active Medical Issues/Medical Services Following Patient:		
Past Medical History:		
Height: ☐ Inches ☐ cm	Weight: ☐ Pounds ☐ Kg	
Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____		
Location: _____		
Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No Frequency: _____ Duration:_____		
Location: _____		

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

Location:_____

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

CCC Specific

Medical Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative ☐ Unknown

Palliative Performance Scale:

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

Pending Investigations: ☐ Yes ☐ No Details:

Frequency of Lab Tests:

☐ Unknown ☐ None

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements?: ☐ Yes ☐ No -- If No, Skip to the 'IV Therapy' Section

Supplemental Oxygen: ☐ Yes ☐ No	Ventilator: ☐ Yes ☐ No	
Breath Stacking: ☐ Yes ☐ No	Insufflation/Exsufflation: ☐ Yes ☐ No	
Tracheostomy: ☐ Yes ☐ No	☐ Cuffed ☐ Cuffless	
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:

IV Therapy

IV in Use?: ☐ Yes ☐ No -- If No, Skip to the 'Swallowing and Nutrition' Section

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

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

Please Include Any Special Diet Concerns:

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Skin Condition

Surgical Wounds and/or Other Wounds Ulcers: ☐ Yes ☐ No -- If No, Skip to the 'Continence' 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*** ***(located at the end of this form).***

Continence

Is Patient Continent?: ☐ Yes ☐ No -- If Yes, Skip to the 'Pain Care Requirements' Section

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

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

Pain Care Requirements

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

Controlled With Oral Analgesics: ☐ Yes ☐ No

Medication Pump: ☐ 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 the 'Cognition' Section

Communication Impairment Description:

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Cognition

Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess -- If No, or Unable to Assess, Skip to the 'Behaviour' Section

Details on Cognitive Deficits:

Has the Patient Shown the Ability to Learn and Retain Information: ☐ Yes ☐ No

If No, Details:

Delirium: ☐ Yes ☐ No

If Yes, Cause/Details:

History of Diagnosed Dementia: ☐ Yes ☐ No

Behaviour

Are There Behavioural Issues: ☐ Yes ☐ No -- If No, Skip to the 'Social History' Section

Does the Patient Have a Behaviour Management Strategy?: ☐ Yes ☐ No

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering

☐ Sun downing ☐ 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

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Current Functional Status

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

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

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

Number of Metres: _____

Weight Bearing Status: ☐ Full ☐ As Tolerated ☐ Partial ☐ Toe Touch ☐ Non

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

Activities of Daily Living

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

Current Status – Complete the Table Below By Selecting One (1) Item Per Row:

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)	☐	☐	☐	☐	☐	☐

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Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No -- If No, Skip to 'Rehab Specific AlphaFim® Instrument Section'

☐ HALO ☐ Orthosis ☐ Bariatric ☐ Other_____

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

{ÎÎIX Å T Rehab Specific AlphaFIM® Instrument

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

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

If Yes – Raw Ratings (levels 1-7):	Transfers: Bed, Chair	•	Expression	•	Transfers: Toilet •
	Bowel Management	•	Locomotion: Walk	•	Memory •
If No – Raw Ratings (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)

Signature:	**Title:**	**Date** DD/MM/YYYY**:**
Contact Number:	**Direct Unit Phone Number:**	