North East Rehab Network

Inpatient Rehabilitation Referral Form

This referral form is to be used for all external referrals to designated inpatient rehabilitation beds in northeastern Ontario. There are five northeastern Ontario hospitals that offer these services – details on the services can be found at the North East Rehab Network website (www.northeastrehabnetwork.ca) under the Admission and Referrals tab, file name: *Designated Rehabilitation Beds in Northeastern Ontario*.

This form is designed to be filled out electronically, then printed and faxed to the facility you have chosen. However, the option of printing out the blank form and filling 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.

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 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 rehab 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, measurable and timely, functional goals for the rehabilitation process.

Please note: If you have any comments or suggestions on how to improve this form please direct your feedback to the North East Rehab Network - specifically Jenn Fearn, Lead, jfearn@hsnsudbury.ca or Andrea Lee, Chair, alee@hsnsudbury.ca

Patient Surname:

Inpatient Rehabilitation Referral Form

Demographics, Referral Information and Medical Information			
Surname:		Given Name:	
Address:		Date of Birth: (Y-M-D)	
City:	Province:	Gender ☐ M ☐ F	Health Card #:
Postal Code:	Home Phone:	Marital Status:	
Language(s) spoken: ☐ English ☐ French ☐ Other (Specify):		Referring Institution:	
Contact Person for Clinical Information:		Phone #:	Pager #:
Contact Person for Bed Offer: ☐ Same as above **OR**:		Phone #:	Pager #:
Infections: ☐ MRSA+ ☐ VRE+ ☐ CDIFF ☐ None Known ☐ Other (Specify):			
Isolation Required: ☐ No ☐ Yes			
Referring Physician:		Phone #:	Fax #:
Primary Rehabilitation Diagnosis:		Date of Onset of Impairment: (Y-M-D)	
History of Presenting Illness:			
Current Active Medical Issues:			
Any pending investigations or follow-up? ☐ No ☐ Yes (Details):			
Past Medical History:			

Social Information

Home living situation, living with:

☐ Spouse/Partner
☐ Family (incl. extended family)
☐ Unknown
☐ Living Alone
☐ Other (Specify):

Support required before admission to acute care:

☐ None
☐ Family (incl. extended family)
☐ Attendant care
☐ Privately-funded care
☐ Meals on Wheels
☐ Other (Specify):
☐ Spouse/Partner
☐ Roommate or Others
☐ CCAC
☐ Unknown

Pre-Admission Accommodation:

☐ House
☐ Apartment Building
☐ Long-term Care Home
☐ Homeless/Hostel
☐ Other (Specify):
☐ Residential Group Home
☐ Retirement Home
☐ Rooming House
☐ Unknown

Describe accommodation barriers that must be dealt with in order for patient to return home:

☐ No barriers
☐ Stairs into dwelling
☐ Stairs to bathroom
☐ Stairs to bedroom
☐ Other (list):

Expected discharge destination post rehab:

☐ Home ☐ LTC ☐ CCC ☐ Shelter/Hostel
☐ Assisted Living (i.e. senior's residence):
☐ Return to Referring Facility:
☐ Other (specify):

Please comment if family is currently actively participating in the patient's treatment and if transferred for further rehab would the family be able to participate?

Has discharge plan been discussed with client/family? ☐ No ☐ Yes
Have back-up plans been discussed? ☐ No ☐ Yes If yes, specify:

Continence

Bladder: ☐ Continent ☐ Incontinent ☐ Occasional Incontinence ☐ Catheter, Type:
☐ Other:

Bowel: ☐ Continent ☐ Occasional Incontinence ☐ Total Incontinence ☐ Other:
☐ Colostomy (brand & size): ☐ Ileostomy (brand & size):

Skin Status

Skin Breakdown: ☐ No ☐ Yes

All Stages/Locations: *(only answer if you said 'Yes' to Skin Breakdown)*

Treatment (Please describe treatment - including therapeutic surfaces)

Swallowing / Nutrition

Swallowing Disorder: ☐ New ☐ Chronic ☐ Not Applicable	If new, has a swallowing assessment been completed? ☐ No ☐ Yes If yes, please attach report

Method of Intake: ☐ ORAL ☐ PEG ☐ NG ☐ NPO ☐ Other (Details):

Coughing/Throat Clearing while eating: ☐ No ☐ Yes	History of Pneumonia: ☐ No ☐ Yes (When)

Sensory Deficits

Are there any visual, auditory, or other sensory deficits? ☐ No ☐ Yes If yes, specify deficit(s) and any appliances:

Communication

Speech: ☐ Receptive Aphasia (difficulty understanding language) ☐ Expressive Aphasia (difficulty producing language)
☐ Dysarthria (slurred speech) ☐ Not Applicable ☐ Other:

Can patient communicate needs? ☐ No ☐ Yes ☐ With Difficulty

Can patient consistently follow one step verbal or gestural commands? ☐ No ☐ Yes

Additional Details:

Cognition/Perception/Motor Planning

Is there a cognitive impairment? ☐ No ☐ Yes ☐ Unable to Assess

Additional Details:

MMSE Score: /30	MOCA Score: /30	Other (Specify): + Score:

Are there any perceptual or motor planning deficits? ☐ No ☐ Yes If yes, please outline:

Has the patient shown the ability to learn and retain information? ☐ No ☐ Yes If no, details:

Does the patient have an adequate attention span to allow participation in activities for 30 minutes at a time?
☐ No ☐ Yes If no, details:

Patient Surname:

Mood/Behaviour

☐ Cooperative ☐ Verbal Aggression ☐ Physical Aggression ☐ Anxiety ☐ Agitation ☐ Wandering
☐ Need for Restraints ☐ Need for Sitter ☐ Sleep Issues ☐ Depression ☐ Exit Seeking ☐ Confusion
☐ Other:

Provide details for all items checked:

Is he/she experiencing adjustment &/or emotional issues? Please specify:

Special Needs/Equipment

Does the patient have any special needs or equipment requirements: ☐ No ☐ Yes, If yes, please specify:

☐ IV therapy ☐ PICC ☐ Oxygen ☐ Tracheotomy ☐ Dialysis ☐ C-Pap ☐ Bi-Pap
☐ Braces/Splints ☐ CADD ☐ Suction ☐ VAC ☐ Special Mattress
☐ Specialized Equipment ☐ Chemotherapy or Radiation Treatment ☐ Other (Specify)

Provide details for **all** items checked:

If Dialysis:
☐ Hemodialysis
☐ Peritoneal

If Specialized Equipment:
☐ Height over 6ft/183 cm (Details:)
☐ Weight over 250 lbs / 113 kg (Details:)

Abilities/Tolerance and Functional Status

Sitting Tolerance: ☐ 30-60 minutes ☐ 1-2 hours ☐ > 2 hours

Physical Activity Tolerance: ☐ 15-30 minutes ☐ 30-60 minutes ☐ 1-2 hours ☐ > 2 hours

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

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

Ambulation: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Has not ambulated

Mobility Aid(s):
☐ Cane , Type:
☐ Crutches, Type:
☐ Walker ,Type:
☐ Wheelchair, Type:
☐ Not Applicable
☐ Other:

Weight bearing (WB) Status:
☐ No restrictions
Left: ☐ As tolerated ☐ Partial lbs ☐ Touch WB ☐ Non WB
Right: ☐ As tolerated ☐ Partial lbs ☐ Touch WB ☐ Non WB

If Non WB or Touch WB, Date to become WB:
OR Reassessment:
Date: Time:
Location: Physician:

Falls:
☐ No ☐ Yes If yes, please specify: ☐ home/community ☐ hospital

History and frequency: ☐ Frequent ☐ Rare ☐ Intermittent

Reason for fall: ☐ Balance ☐ Vision ☐ Strength ☐ Fatigue ☐ Decreased insight/judgment ☐ Unknown

☐ Other (Specify)

Current Function in Upper and Lower Extremities

Limbs: ☐ Normal ☐ Left sided impairment ☐ Right sided impairment ☐ Bilateral impairment
☐ U/E Impairment ☐ L/E impairment ☐ Impaired coordination ☐ Reduced strength
☐ Other *(specify)*

Details /Other info:

Patient Surname:

Activities of Daily Living (ADLs) (please indicate level for each activity with an X)						
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)						

Previous Functional Status

Were there **any** functional deficits prior to onset of current disability (including cognitive impairment)? If so, please outline:

Valid Driver's License: ☐ No ☐ Yes

If yes, has change in medical status been reported to the Ministry of Transportation: ☐ No ☐ Yes

Employment status/Occupation:

Goals

Patients Goals:

Have the goals been discussed with the patient: ☐ No ☐ Yes

Progress/Participation

Please outline patient progress to date:

Patient receives therapies?: ☐ No ☐ Yes

If yes, specify type (PT, OT, SLP, SW,RT) and frequency:

Does the patient demonstrate the ability and motivation to actively participate in therapies?: ☐ No ☐ Yes

Can he/she remember the activity between sessions? ☐ No ☐ Yes If No, (Details):

Other Comments/Issues

Is the patient willing /motivated to participate at a rehabilitation centre outside of town: ☐ No ☐ Yes

Any other comments/issues that you feel the Rehabilitation Team should be aware of (i.e. family expectations, severe allergies, history of substance abuse)?

Patient Surname:

Inpatient Rehabilitation Referral Form

Please Send:

- ☐ All relevant cognitive perceptual testing (MMSE, MOCA, etc.)
- ☐ All relevant investigations (X-RAY, CT, MRI, US, ECHO, Swallowing Ax, etc.)
- ☐ All recent laboratory investigations
- ☐ Current list of medication
- ☐ Current Physician History
- ☐ All relevant health professional notes (PT, OT, SLP, etc.)

Contacts: (as appropriate)	**Designation**	**Phone #/Ext.**
	PT	
	OT	
	SW	
	SLP	
	RD	
	Nursing	
	Other:	

Have you applied to another Rehabilitation Centre?

☐ No ☐ Yes, If yes, please specify and provide date(s) applied:

Form Completed by: _____

(Name, designation, phone number/ext.) Please print, unless filled out electronically

Signature:_____ **Date:**_____

FAX completed referral form and supporting documentation to your selected facility:

Health Sciences North
Colleen Bronicheski, RN
Clinical Manager, Intensive Rehab Unit
Fax (705) 523-7091

Sault Area Hospital
Toni MacLeod, RN
Patient Care Manager, Rehabilitation and Complex Continuing Care Units
Fax (705) 256-3465

Timmins and District Hospital
Lia Holmes, BA, RSSW
Social Work/Discharge Planning, Rehabilitation/ Complex Continuing Care/Interim LTC
Fax (705) 267-6301

North Bay Regional Health Centre
Lindsay Brown, RSW
Social Worker/Discharge Planner, Rehabilitation Unit
Fax (705) 495-7959

West Parry Sound Health Centre
Cathy Hennigar, RN
Discharge Planner
Fax (705) 773-4054

Internal Office Use: Videoconference required? ☐ No ☐ Yes

Patient Surname: