GTA REHAB NETWORK

INPATIENT REHAB/CCC REFERRAL FORM*

The ***Inpatient Rehab/CCC Referral Form*** is to be used for referrals to inpatient rehabilitation or Complex Continuing Care (CCC) offered by the GTA Rehab Network member organizations.

This referral package is to be used for all rehab and CCC referrals ***except:***

- Elective Total Joint Replacements and uncomplicated Elective Cardiac Bypass/Valve Surgery (Streamlined referral process already in place)
- Palliative Care - (Plans for integration underway)
- E-Stroke - Referrals are to be made through the electronic E-Stroke Rehab Referral System. For those organizations that do not have access to the E-Stroke Rehab Referral System, please download the PDF version of the E-Stroke Rehab Referral form from the GTA Rehab Network's website at: http://www.gtarehabnetwork.ca/referral_forms.asp .

(Note: Referrals for Geriatric Psychiatry at Toronto Rehab are to be made using Toronto Rehab's existing application form.)

For each referral, please complete the following and fax directly to the programs you are requesting:

1. *Acute Care to Inpatient Referral Form*: (includes Demographic, Referral, Social, Acute Care Medical Assessment, Care Requirements and Consent sections)
2. A *functional form* relevant to the rehab population being referred. Please use your clinical judgment to determine which functional would be most appropriate to give the best clinical picture of the patient. For example, the geriatric functional may be more appropriate to describe the functional needs of an older patient referred for MSK rehab.
3. For CCC referrals (other than referrals for Low Tolerance Long Duration / slow stream rehab), please complete the *CCC functional form.*

Attachments required:

✓ Medication list
✓ Abnormal CT Scan results
✓ Chemotherapy protocol, lab monitoring requirements, clinical impacts (oncology patients only)

Optional attachments:

✓ Social Work report
✓ Behavioural supplemental information

Sending of Updates:

For the majority of referrals, the sending of updates is not needed. However, in the event that there is any *significant* change/deterioration in the patient's status (i.e. medical, functional, infection status and or equipment needs), notify the inpatient rehab/CCC facility via telephone and/or by faxing medical notes and/or OT/PT/SLP notes.

Discharge/Transfer Checklist:

Upon transfer of patient, please refer to the ***Discharge/Transfer Checklist*** regarding the information that is to be sent with the patient to the post-acute destination.

*Copies of the Inpatient Rehab/CCC Referral Form can be downloaded from the GTA Rehab Network's website at http://www.gtarehabnetwork.ca/referral_forms.asp.

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 1: DEMOGRAPHIC INFORMATION

To be completed by Social Worker/Discharge Planner/Case Manager

INPATIENT REHAB/CCC REFERRAL

Please complete the Inpatient Rehab/CCC Referral Form ***and*** a population-specific functional form. Send the completed copies via fax to the program requested.

PATIENT REGISTRATION

Patient's first name	**Last name**
Sex ☐ M ☐ F	**DOB** (YYYY-MM-DD)

Health Card Number	**Version**	**Expiry Date (If available)**	**Province/Territory issuing Health Card** ☐ Ontario ☐ Other (Specify)

DEMOGRAPHICS

Home Address

Postal Code	**Home Telephone 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)

Other relevant cultural considerations (specify)

EMERGENCY CONTACT

Relationship to patient: ☐Spouse ☐ Partner ☐ Son/Daughter ☐ Sibling ☐ Parent ☐ Relative ☐ Friend ☐ Other (specify):____________

Is the Emergency Contact a substitute decision-maker? ☐ Yes ☐ No

Name:

Address:	City/Prov:	Postal Code:
Daytime Phone:	Evening Phone:	

RESPONSIBILITY FOR PAYMENT *Source; CIHI NRS*

☐ OHIP	☐ Federal Government	☐ IFH (Interim Federal Health Grant)
☐ Inter-provincial Insurance Plan	☐ Insured/Self Pay	☐ Other Payment Sources
☐ WSIB	☐ Uninsured/Self Pay	☐ Unknown

If insurance payment

Name of insurer ______________________ Claim # ________________________ Certificate #______________________

Group Number _______________________ Policy # ________________________

Completed by:	**Phone:**	**Date:**

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 2: REFERRAL INFORMATION

To be completed by Social Worker/Discharge Planner/Case Manager

Patient's Name	
Patient's admission date to this facility (YYYY-MM-DD)	**Attending Physician**
Referring facility	
Program Name and Service	
Bed Offer Contact (name and number/pager)	**Fax number**
Primary Contact ☐ Same as above. If different, specify name, number/pager and fax number.	
Date Referral Completed (YYYY-MM-DD)	
Anticipated date ready for rehab[1] or ready for transfer to rehab/CCC (YYYY-MM-DD)	
If early referral (e.g., patient to be weaned off of NG tube, IV to be taken out) specify if special needs are expected to resolve.	
Comment	

Inpatient setting type requested

☐ Rehab: High Tolerance/Regular stream
☐ Rehab: Low Tolerance Long Duration (LTLD/slowstream)
☐ Complex Continuing Care (CCC)

Rehab/CCC population requested

☐ ABI	☐ Amputee	☐ Burns	☐ Cardiac
☐ Chronic Ventilation	☐ General/Medical	☐ Geriatric	☐ MSK
☐ Neuro	☐ Oncology	☐ Respiratory Rehab	
☐ Spinal Cord	☐ Trauma	☐ Transplant	
☐ Other_______			

Organizations referred to: (Rank client preference in check boxes)

___ Baycrest	___ Markham Stouffville Hospital	___ St. John's Rehab Hospital	___ West Park Healthcare Centre
___ Bridgepoint Health	___ Providence Healthcare	___ Toronto East General Hospital	___ William Osler Health Centre
___ Credit Valley Hospital	___ Rouge Valley Health System	___ Toronto Grace Health Centre	___ York Central Hospital
___ Halton Healthcare Services	___ Runnymede Healthcare Centre	___ Toronto Rehab	___ Other (specify):_____________
___ Lakeridge Health	___ Southlake Regional Health Centre	___ Trillium Health Centre	

Preferred accommodation

☐ Ward ☐ Semi private ☐ Private ☐ Isolation ☐ Other (specify): ______________________________

☐ Co-payment fees reviewed (where appropriate)

Additional referral comments

Completed by:	**Phone:**	**Date:**

[1] Ready for rehab: Refer to Inpatient Rehab/LTLD Referral Guidelines GTA Rehab Network 2009, www.gtarehabnetwork.ca/referral_guide.asp

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 3: SOCIAL INFORMATION

To be completed by Social Worker

Patient's Name:

PERSONAL CARE	FINANCES
Who manages the patient's PERSONAL CARE decisions now? ☐ Self ☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian ☐ Public Guardian/Trustee ☐ Others ☐ Don't know **If other than Self, list contact information, PERSONAL CARE** Name: ______________________________ Relationship to patient: ☐Spouse ☐ Partner ☐ Son/Daughter ☐ Sibling ☐ Parent ☐ Relative ☐ Friend ☐ Appointed ☐ Other	**Who manages the patient's FINANCES now?** ☐ Same as contact person, PERSONAL CARE **or** ☐ Self ☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian ☐ Public Guardian/Trustee ☐ Others ☐ Don't know **If other than Self or Personal Care decision maker, list Contact Person and contact information, FINANCES** Name: ______________________________ Relationship to patient: ☐Spouse ☐ Partner ☐ Son/Daughter ☐ Sibling ☐ Parent ☐ Relative ☐ Friend ☐ Appointed ☐ Other
Address: City/Prov: Postal Code:	Address: City/Prov: Postal Code:
Daytime Phone: Evening Phone:	Daytime Phone: Evening Phone:
Financial Information: *(Adapted from CIHI NRS)* ☐ WSIB ☐ EI ☐ STD ☐ LTD ☐ CPP ☐ OAS ☐ ODSP ☐ Ontario Works ☐ Self-Employed ☐ Employed ☐ Veteran ☐ No income ☐ Auto Insurance *(provide name of insurance co., adjustor):*	**Marital Status:** ☐ Single ☐ Separated ☐ Unknown ☐ Married ☐ Divorced ☐ Common Law ☐ Widowed
Home living situation, living with: *(Adapted from CIHI-NRS)* ☐ Spouse/Partner ☐ Living Alone ☐ Family (including extended family) ☐ Not applicable ☐ Others ☐ Unknown	**Support required before admission to acute care:** ☐ None ☐ Spouse/Partner ☐ Family support (including extended family) ☐ Roommate or others ☐ Attendant care ☐ CCAC ☐ Privately-funded care ☐ Other (Specify):
Pre-Admission Accommodation: ☐ House ☐ Long-term Care Home ☐ Homeless/Hostel ☐ Apartment Building ☐ Rooming House ☐ Unknown ☐ Retirement Home ☐ Residential Group Home ☐ Other (Specify):	**Describe accommodation barriers that must be dealt with in order for patient to return home:** ☐ No barriers ☐ Stairs to bedroom ☐ Stairs into dwelling ☐ Don't know ☐ Stairs to bathroom ☐ Other (list):
Caregiver support post-rehab can be provided by: (Check all that apply) ☐ None ☐ Spouse/Partner ☐ Family support (including extended family) ☐ Roommate or Others ☐ Attendant care ☐ CCAC ☐ Privately-funded care ☐ Other (Specify):	**Expected discharge destination post rehab:** ☐ Home ☐ LTC ☐ CCC ☐ Assisted Living (e.g. seniors building) ☐ Shelter/Hostel ☐ Don't know ☐ Other (specify) Has discharge plan been discussed with client/family? ☐ Yes ☐ No Have back-up plans been discussed? ☐ No ☐ Yes If yes, specify:

Comments regarding social situation/issues: ☐ Social Work Report Attached

Completed by:	Telephone:	Date:

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 4: ACUTE CARE MEDICAL ASSESSMENT

To be completed by Physician or Physician Designate

Patient's Name: ______________________________

Primary Diagnosis: ______________________________

____

Past and relevant surgical history: ☐ No ☐ Yes If yes, specify: ______________________________

____

Current surgical intervention(s) with date(s): ______________________________

____

____

Clinical course in hospital (e.g. infections, surgical complications): ______________________________

____

____

____

Past & relevant medical history (e.g. cardiovascular conditions, orthopaedic conditions or other):

____

____

____

Relevant psychiatric history: ☐ No ☐ Yes If yes, describe history, current status, attach recent consult notes and provide details of follow-up arrangements: ______________________________

____

____

Head CT Scan Results	Other CT Scan Results	MRI Results
☐ N/A ☐ Normal ☐ Abnormal -- attach results	☐ N/A ☐ Normal ☐ Abnormal -- attach results	☐ N/A ☐ Normal ☐ Abnormal -- attach results

Medication: <u>Attach MAR</u>. Is patient receiving atypical/study drugs? ☐ No ☐ Yes If yes, please specify drug(s), availability and costs:

____

____

____

Weight bearing status: ☐ No restrictions

<u>Left:</u> ☐ As tolerated ☐ Partial__________lbs ☐ Touch weight bearing ☐ Non weight bearing.
Precautions and restrictions: ______________________________ Date to become weight bearing: ____________________

<u>Right:</u> ☐ As tolerated ☐ Partial__________lbs ☐ Touch weight bearing ☐ Non weight bearing.
Precautions and restrictions: ______________________________ Date to become weight bearing: ____________________

<u>For Oncology Patients only:</u>

Summary of current cancer picture: ☐ Radiotherapy Specify start date, duration & frequency: ______________________________

☐ Chemotherapy (Specify): ☐ Oral ☐ IV ☐ Other (Attach protocol, lab monitoring requirements, anticipated side effects and other clinical impacts.)

Haemoglobin and White Blood Cell Count done within last week? ☐ Yes ☐ No **Results:** ______________________________

Have end of life care issues been discussed with: Patient? ☐Yes ☐ No Family? ☐ Yes ☐ No ☐ N/A

Please specify any issues/concerns: ______________________________

____

Referring Physician/Designate: I authorize a referral for this individual for the hospital/agency/program specified.

Name: ______________________________ Phone: ( ) ________________ Signature: ______________________________ Date: ____________

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 5: CARE REQUIREMENTS

To be completed by Nursing

Patient's Name:

Smoker: ☐ No ☐ Yes ☐ Independent/Safe

Weight: ☐ 300 lbs (136 Kg) or more

Height: ____________ ☐ Inches ☐ Centimetres ☐ Unknown

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

Allergies: ☐ **NKDA** ☐ **Yes If yes, list allergies:**

Diet: ☐ Regular ☐ Kosher ☐ Diabetic ☐ Renal ☐ Low Sodium ☐ Other (specify):

Fully Oriented? ☐ Yes ☐ No If no, specify below:

Oriented to: ☐ Person ☐ Place ☐ Time

Comments:

Behavioural Issues: ☐ No ☐ Yes If yes, please describe or ✓ if supplemental information attached ☐ (For ABI patients, see ABI functional section for more information.)

Infection Control - Does individual currently have:

MRSA: ☐ No ☐ Yes Location: ________________________ VRE: ☐ No ☐ Yes Location: ________________________

C-Difficile: ☐ No ☐ Yes Other: (Specify) ____________________________________

Safety Support required:

☐ N/A ☐ Requires bed rails ☐ Requires Geri chair ☐ Requires Hoyer/Mechanical lift

Wandering risk:

☐ N/A ☐ Indoor ☐ Outdoor ☐ Wander guard ☐ Exit Seeker

Restraints used:

☐ N/A ☐ Physical ☐ Chemical ☐ Lap belt

☐ Wrist restraint ☐ One-to-one ☐ Other

Reason:

☐ Exit-seeking, at risk for elopement ☐ Agitated, may harm self or others

☐ Safety (e.g. at risk for falls) **Frequency:**______________________________

Falls:

☐ No ☐ Yes If yes, specify: ☐ home/community ☐ hospital **History & Frequency:** ☐ Frequent ☐ Rare ☐ Intermittent

Reason for fall:

☐ Balance ☐ Vision ☐ Strength ☐ Fatigue ☐ Decreased insight/judgment ☐ Unknown ☐ Other (list):

SPECIAL NEEDS: Indicate the special needs of the patient.

Tracheostomy: ☐ N/A ☐ Cuffed ☐ Uncuffed

Size: ___________ Brand ______________________

Frequency of suctioning ____________________________

Intravenous: ☐ N/A ☐ Central Line ☐ Peripheral Line

☐ Portacath ☐ Other_____________

Oxygen: ☐ N/A

☐ Intermittent Oxygen __________ L/min ☐ Constant Oxygen ________L/min

☐ 02 at rest __________ L/min ☐ 02 at exercise_______ L/min☐ BIPAP ☐ CPAP

Enteral Feeding: ☐ N/A

☐ NG Tube ☐ GJ Tube ☐ J Tube ☐ G Tube

Specify type & rate of feeds:

Dialysis: ☐ N/A ☐ Peritoneal Dialysis ☐ Hemodialysis

Accessibility to Dialysis Centres: ☐ Family drives ☐ Volunteer drives ☐ Wheel-Trans ☐ Other__________________

Treatment Dates/Times/Location (specify):

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 5: CARE REQUIREMENTS (cont'd)

To be completed by Nursing

Patient's Name:

Ventilation: ☐ N/A ☐ Chest Tube
☐ Ventilation Specify type of vent:

Skin condition: ☐ Intact ☐ Not intact ☐ One Site ☐ Multiple Sites ☐ Vac Therapy ☐ Burn

Location

Braden staging grade	**Size**

Treatment Details

Equipment Needs: ☐ N/A

	Equipment details/procedures
☐ Bariatric ☐ Special Bed ☐ Special Mattress ☐ Other (specify):	

Bladder Management: ☐ N/A

	Treatment details/procedures
☐ Indwelling catheter ☐ Intermittent catheterization ☐ Condom catheter ☐ Using incontinent product ☐ Toileting assistance required ☐ Occasional incontinence ☐ Total incontinence ☐ Bladder retention/Bladder scanned	

Bowel Management: ☐ N/A

	Treatment details/procedures
☐ Toileting assistance required ☐ Occasional incontinence ☐ Total incontinence ☐ Using incontinent product	

Ostomy: ☐ N/A ☐ Yes	
Ability to care for ostomy: ☐ Independent ☐ Total care ☐ Requires supervision	**Type/brand and care/products required**

Completed by:	**Phone:**	**Date:**

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 6: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager)**:**

☐ I agree that ______________________________
(Name of facility disclosing information)

may release my personal health information to make a referral.

Organizations referred to:

___ Baycrest
___ Bridgepoint Health
___ Credit Valley Hospital
___ Halton Healthcare Services
___ Lakeridge Health
___ Markham Stouffville Hospital
___ Providence Healthcare
___ Rouge Valley Health System
___ Runnymede Healthcare Centre
___ St. John's Rehab Hospital
___ St. John's Rehab Hospital
___ Toronto East General Hospital
___ Toronto Grace Health Centre
___ Toronto Rehab
___ Trillium Health Centre
___ West Park Healthcare Centre
___ William Osler Health Centre
___ York Central Hospital
___ Other (specify): ______________

To be completed for all referrals:

Print Name of Patient: ______________________________

Signature of Patient/Substitute: ______________________________ Date:(YYYY/MM/DD)______________

Name of Substitute: ______________________________
(print name)

Relationship to patient, if signed by Substitute: ______________________________

☐ Yes, an interpreter was used when consent was obtained.
☐ No interpreter was required.

GTA REHAB NETWORK

FUNCTIONAL INFORMATION – ABI or Neuro

To be completed by Allied Health Team

Patient's Name:

Date of injury/event: ______ / ______ / ______
year month day

Nature/type of injury/event: ☐ MVC ☐ MVC *(motorcycle)* ☐ MVC *(on bicycle/pedestrian)* ☐ Fall ☐ Assault ☐ Sporting
☐ Trauma-other *(specify)* ______ ☐ unknown

☐ Non-trauma *(specify)* ______

Glasgow Coma Score on admission *(if available)*: ______

Previous history of ABI: ☐ No ☐ Yes Describe: ______

Seizures: ☐ No ☐ Yes Dates: ______ Describe: ______

Loss of consciousness: ☐ No ☐ Yes Coma length: ______

Post Traumatic Amnesia: ☐ No ☐ Yes Duration: ______

Pre-Injury History of Substance Abuse: ☐ Yes ☐ No ☐ History not available Status on admission: ______

Current Substance Abuse: ☐ Yes ☐ No ☐ Not known

Substance Abuse Treatment Recommended: ☐ Yes ☐ No

Neuro-ophthalmology consult conducted: ☐ Yes ☐ No
Visual acuity testing completed: ☐ Yes ☐ No

Visual field testing completed: ☐ Yes ☐ No
Include Results: ______

Premorbid function: ☐ Independent in ADL ☐ Dependent in ADL ______

Self Care:

Dressing: ☐ Independent ☐ Total assistance ☐ Partial assistance ☐ Supervision only

Bathing: ☐ Independent ☐ Total assistance ☐ Partial assistance ☐ Supervision only

Swallowing: ☐ Intact, regular diet ☐ Dental soft diet ☐ Minced diet ☐ Pureed diet
☐ Thickened fluids

Feeding: ☐ Independent ☐ Total assistance ☐ Needs partial assistance ☐ Supervision required
☐ Tube feed *(specify)* ______

Transfers: ☐ Independent ☐ Mechanical lift ☐ 2 person ☐ 1 person ☐ Supervision only
☐ On bed rest

Transfer aide: ☐ Standard Walker ☐ Rollator ☐ Wheelchair ☐ Cane ☐ Crutches
☐ 2 Wheeled Walker ☐ Other (specify)

Ambulation: ☐ Non-ambulatory ☐ 2 person ☐ 1 person ☐ Supervision only ☐ Independent
☐ Distance *(specify)* ______

Limbs: ☐ Normal ☐ Left sided impairment ☐ Right sided impairment ☐ Bilateral impairment
☐ U/E impairment ☐ L/E impairment ☐ Impaired coordination ☐ Reduced strength
☐ Other ______

FUNCTIONAL INFORMATION – ABI or Neuro

To be completed by Allied Health Team

Chair Sitting Tolerance: Specify minutes: ______________________________

Participation Level:

Specify: On average, patient is able to participate in ________ therapy sessions / day, ________times / week for ___________minutes / session.

Rancho Los Amigos Cognitive Scale at present: ________________________

Behavioural Issues: ☐ No ☐ Yes (If yes, please check where applicable and describe, listing interventions used):

☐ Physical aggression ☐ Verbal aggression ☐ Self abuse ☐ Inappropriate sexual behaviour ☐ Wandering ☐ Other *(specify)*

____

____

____

Communication:

Language expression: ☐ Intact ☐ Dysarthria ☐ Only able to express basic needs ☐ Uses gesturing ☐ Completely impaired

Language comprehension: ☐ Intact ☐ Follows basic instructions ☐ Impaired ________________________________

Other comments: ____

Cognitive Status:	Not Tested	Intact	Impaired
Orientation	☐	☐	☐ *(specify)* ______________________________
Attention:	☐	☐	☐ *(specify)* ______________________________
Memory (short term)	☐	☐	☐ *(specify)* ______________________________
Memory (long term)	☐	☐	☐ *(specify)* ______________________________
Carry-Over/New Learning	☐	☐	☐ *(specify)* ______________________________
Judgment	☐	☐	☐ *(specify)* ______________________________
Insight	☐	☐	☐ *(specify)* ______________________________
Frustration Tolerance	☐	☐	☐ *(specify)* ______________________________
Other	☐	☐	☐ *(specify)* ______________________________

Briefly describe the rehabilitation goals *(Be specific — e.g. increased mobility, speech, community living skills, etc.)*

PT Progress & Plan

OT Progress & Plan

SLP Progress & Plan

Form completed by: (Include name/telephone/date)