

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 - (Integration with the E-Stroke Rehab Referral System will be pursued in future once the paper-based form evolves into an electronic format.) 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 to the programs requested:

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*.

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.

Transfer Checklist:

Upon transfer of patient, please refer to the ***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

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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 (YY-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 MinimalInterpreter 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 INFO

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 <input type="checkbox"/> Same as above. If different, specify name, number/pager and fax number.	
Date Referral Completed (YYYY-MM-DD)	
Anticipated date ready for rehab¹ 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 <input type="checkbox"/> Rehab: High Tolerance/regular stream <input type="checkbox"/> Rehab: Low Tolerance Long Duration (LTLD/slowstream) <input type="checkbox"/> Complex Continuing Care (CCC)	Rehab/CCC population requested <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> Chronic Ventilation <input type="checkbox"/> General/Medical <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neuro <input type="checkbox"/> Oncology <input type="checkbox"/> Respiratory Rehab <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Trauma <input type="checkbox"/> Transplant <input type="checkbox"/> Other (specify):
Organizations referred to: (Rank client preference in check boxes)	
<input type="checkbox"/> Baycrest <input type="checkbox"/> Bridgepoint Health <input type="checkbox"/> Credit Valley Hospital <input type="checkbox"/> Halton Healthcare Services <input type="checkbox"/> Lakeridge Health	<input type="checkbox"/> Markham Stouffville Hospital <input type="checkbox"/> Providence Healthcare <input type="checkbox"/> Rouge Valley Health System <input type="checkbox"/> Southlake Regional Health Centre <input type="checkbox"/> St. John's Rehab Hospital
<input type="checkbox"/> Toronto East General Hospital <input type="checkbox"/> William Osler Health Centre <input type="checkbox"/> Toronto Grace Health Centre <input type="checkbox"/> York Central Hospital <input type="checkbox"/> Toronto Rehab <input type="checkbox"/> Trillium Health Centre <input type="checkbox"/> West Park Healthcare Centre <input type="checkbox"/> Other (specify):	
Preferred accommodation	
<input type="checkbox"/> Ward <input type="checkbox"/> Semi private <input type="checkbox"/> Private <input type="checkbox"/> Isolation <input type="checkbox"/> Other: (specify) <input type="checkbox"/> Co-payment fees reviewed (where appropriate)	
Additional referral comments	
Completed by:	Phone:
Date:	

¹Ready for rehab: Refer to inpatient Rehab Referral Guidelines GTA Rehab Network 2006, www.gtarehabnetwork.ca/referral_guide.asp

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 3: SOCIAL INFORMATION

To be completed by Social Worker

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Patient's Name: _____

PERSONAL CARE	FINANCES
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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

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, list contact information, PERSONAL CARE

 Name: _____
 Relationship to patient: Spouse Partner Son/Daughter
 Sibling Parent Relative Friend Appointed
 Other: _____

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:
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Address:	City/Prov:	Postal Code:
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Daytime Phone:	Evening Phone:
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Daytime Phone:	Evening Phone:
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Financial Information Adapted from CIHI NRS
 WSIB EI STD LTD CPP OAS ODSP
 Ontario Works Self-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:
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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: <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe history, current status, attach recent consult notes and provide details of follow-up arrangements:		
Head CT Scan Results <input type="checkbox"/> N/A <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (attach results)	Other CT Scan Results <input type="checkbox"/> N/A <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (attach results)	MRI Results <input type="checkbox"/> N/A <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (attach results)
Medication: <u>Attach MAR</u>. Is patient receiving atypical/study drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify drug(s), availability and costs:		
Weight bearing status Left: <input type="checkbox"/> As tolerated <input type="checkbox"/> Partial ____ lbs		
		<input type="checkbox"/> Touch weight bearing <input type="checkbox"/> Non weight bearing.
Precautions and restrictions:		Date to become weight bearing: ____
Right: <input type="checkbox"/> As tolerated <input type="checkbox"/> Partial ____ lbs		
		<input type="checkbox"/> Touch weight bearing <input type="checkbox"/> Non weight bearing.
Precautions and restrictions:		Date to become weight bearing: ____
For Oncology Patients only:		
Summary of current cancer picture: <input type="checkbox"/> Radiotherapy Specify start date, duration & frequency: ____		
<input type="checkbox"/> Chemotherapy Specify: <input type="checkbox"/> Oral <input type="checkbox"/> IV Attach protocol, lab monitoring requirements, anticipated side effects and other clinical impacts.		
Haemoglobin and White Blood Cell Count done within last week? <input type="checkbox"/> Yes <input type="checkbox"/> No Results: ____		
Have end of life care issues been discussed with: Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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

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Patient's Name: _____

Weight: _____ Lbs Kilos **Smoker:** No Yes Independent/Safe **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 **List allergies:** _____

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

Fully Oriented? Yes No. If no, specify below: _____ **Comments:** _____
Disoriented to: Time Person Place

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 (specify): _____

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.

Tracheotomy: 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 O2 at rest: _____ L/min
 O2 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): _____

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SECTION 5: CARE REQUIREMENTS

To be completed by Nursing

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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

<input type="checkbox"/> Bariatric <input type="checkbox"/> Special Bed <input type="checkbox"/> Special Mattress <input type="checkbox"/> Other (specify): _____	Equipment details/procedures:
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Bladder Management: N/A

<input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Intermittent catheterization <input type="checkbox"/> Condom catheter <input type="checkbox"/> Using incontinent product <input type="checkbox"/> Toileting assistance required <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Total incontinence <input type="checkbox"/> Bladder retention/Bladder scanned	Treatment details/procedures:
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Bowel Management: N/A

<input type="checkbox"/> Toileting assistance required <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Total incontinence <input type="checkbox"/> Using incontinent product	Treatment details/procedures:
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Ostomy: N/A Yes

Ability to care for ostomy: <input type="checkbox"/> Independent <input type="checkbox"/> Total care <input type="checkbox"/> Requires supervision	Type/brand and care/products required:
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Completed by:	Phone:	Date:
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ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 6: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

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

To be completed for all referrals:

- I agree that _____ (Name of facility disclosing information) may release my personal health information for the purpose of facilitating a referral.

Organizations referred to:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Baycrest | <input type="checkbox"/> Markham Stouffville Hospital | <input type="checkbox"/> Toronto East General Hospital | <input type="checkbox"/> William Osler Health Centre |
| <input type="checkbox"/> Bridgepoint Health | <input type="checkbox"/> Providence Healthcare | <input type="checkbox"/> Toronto Grace Health Centre | <input type="checkbox"/> York Central Hospital |
| <input type="checkbox"/> Credit Valley Hospital | <input type="checkbox"/> Rouge Valley Health System | <input type="checkbox"/> Toronto Rehab | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Halton Healthcare Services | <input type="checkbox"/> Southlake Regional Health Centre | <input type="checkbox"/> Trillium Health Centre | |
| <input type="checkbox"/> Lakeridge Health | <input type="checkbox"/> St. John's Rehab Hospital | <input type="checkbox"/> West Park Healthcare Centre | |

For Acquired Brain Injury (ABI) referrals only:

Summaries of your referral information may be used by the Toronto ABI Network to identify trends in use of health services and to help answer research questions about the type of rehab applied for and course of treatment. Your information would be collected from the system then combined with the information of other patients. Your name and personal health information would not be used in any public reporting. A Research Ethics board must approve all research projects before your information can be used. If you do not want your personal health information to be used, this decision will not affect your medical care in any way.

- Yes, my health information may be used for system improvement & research purposes. My health information will be made anonymous for this purpose.
- No, my health information may not be used for system improvement & research purposes.

For e-Referrals only:

Your care team uses an electronic referral system to share your health information with your care providers. The system is set up so that only your health care team can see your information. Using an electronic referral system speeds up referrals, helps improve quality of care for patients by providing information needed to learn about delays and challenges that can happen with a referral process and health care system. Your information in the system may be used by researchers and for system planning purposes. Your information would be collected from the system then combined with the information of other patients. Your name and personal health information would not be used in any public reporting. A Research Ethics board must approve all research projects before your information can be used. If you do not want your personal health information to be used, this decision will not affect your medical care in any way.

- Yes, my health information may be used for system improvement & research purposes. My health information will be made anonymous for this purpose.
- No, my health information may not be used for system improvement & research purposes.

Print Name of Patient: _____

Signature of Patient/Substitute: _____

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.

Date:(YYYY/MM/DD) _____