ACUTE CARE TO INPATIENT REHAB

Section 1: Demographic Information

To be completed by Social Worker/discharge Planner/Case manager

Inpatient Rehab Referral Please fax completed application form to (705) 526-0069	
PATIENT REGISTRATION	
Patient's first name:	**Last name:**
Sex M F	**DOB**
Health Card Number Version Expiry Date(if available) Province/Territory issuing health care **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	
Patient's admission date (referring facility)	**Attending Physician**
Referring facility	
Bed Offer Contact (name and number/pager)	**Fax number**
Primary Contact same as above if different, specify name, number/pager and fax number	
Anticipated date ready for rehab or ready for transfer to rehab/CCC	
If early referral (e.g., patient to be weaned off of NG tub, IV to be taken out) specify if special needs are expected to resolve.	
Emergency Contact/Next of Kin/Substitute Decision Maker	**Name: _____ Address: _____** **Home phone (___) _____ Bus Phone (___)_____** **Relationship: Spouse/Partner Daughter/Son Parent Sibling Other** **Identified as: Emergency Contact Next of Kin POA (Personal Care) POA(Finance) SDM**

Section 2: Social Information

Home living situation, Living with Spouse/Partner Lives alone Family (including extended family Retirement Home Nursing Home Other	**Marital Status:** Single Separated Unknown Married Divorced Common Law Widowed
Caregiver support post-rehab can be provided by: None Spouse Family support (including extended family Roommate or others Attendant Care CCAC privately-funded Care 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 Stairs to bathroom Other (list)
Expected discharge destination post rehab: Home LTC CCC Assisted Living (e.g. seniors building) Shelter/Hostel don't know Other (specify)	
Comments regarding social situation/issues: Social Work Report Attached	

Rehab Goals:
Have discharged plans post rehab been discussed?
Have discharge plans post rehab been arranged?

SECTION 3: MEDICAL ASSESSMENT

To be completed by Physician or Physician Designate (Registered Nurse)

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, orthopedic 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: Attach MAR. Is patient receiving atypical/study drugs?

Referring physician/Designate: I authorize a referral for this individual for inpatient rehabilitation

Name: _____ Phone ( ) _____

Signature _____ Date _____

SECTION 4: CARE REQUIREMENTS

To be completed by Nursing

Weight 300lbs (136kg) or more	**Height:_____** Inches Centimeters 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 Diabetic Renal Low sodium Other (specify):	
Fully Oriented? Yes No if no, specify below: **Oriented to**: Person Place Time	**Comments:**
Behavioral Issues: No Yes If yes, please include additional information/progress notes	
Infection Control – Does individual currently have: MRSA: No Yes Location;_____ VRE: No Yes Location:_____ C-Difficile: No Yes Other (Specify)_____	
Wandering Risks: N/A Indoor Outdoor Exit Seeker	
Restraints used: N/A Physical Chemical Lap belt Wrist restraint One-to-one Other	**Reason:** Exit-seeking, at is 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)	
Oxygen: N/A Intermittent Oxygen ____L/min constant Oxygen _____L/min O2 at rest ____L/min 02 at exercise L/min BIPAP CPAP	**Intravenous:** N/A Central line Peripheral Line Portacath Other
Skin Condition: intact not intact one site multiple Sites Vac Therapy Burn	
Location	

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Braden staging grade	**Size**
Treatment Details	
Equipment Needs: N/A	
Bariatric Special Bed Special Mattress Other (specify)	**Equipment details/procedures**
Bladder management: N/A	
Indwelling Catheter Intermittent Catheterization Condom catheter using incontinent product Toileting assistance required Occasional incontinence Total incontinence Bladder retention/bladder scanned	**Treatment details/procedures**
Bowel Management: N/A	
Toileting assistance required Occasional incontinence Total incontinence Using incontinent product	**Treatment details/procedures**
Ostomy; N/A yes	
Ability to care for ostomy: independent Total care Requires supervision	**Type/brand and care/products required**

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

SECTION 5: PHYSIO/OCCUPATIONAL THERAPY

To be completed by physiotherapy

*Physiotherapy/Occupation Therapy: please ensure that the following are clearly articulated: Weight bearing status, Activity tolerance, Ability to follow instructions, Sitting tolerance, Type of walker, and details of prosthesis if applicable

Patients/Client Name: _____

Height: _____ Smoker
Weight: _____lbs Yes No

Activities of Daily Living
Chewing: Difficulty: Yes No Dentures: Yes No Pureed Diet: Yes No
Swallowing: Intact/ Regular diet Dental soft Minced diet Pureed diet
Thickened fluids
Feeding: Independent Supervision required needs partial assistance
Total assistance
Incontinence not applicable Bowel Bladder Catheter
Condom

Weight Bearing Status:
As tolerated Partial _____% Touch Weight Bearing
non Weight Bearing
Other precautions and restrictions:_____

Mobility:
Transfers: mechanical lift 2 person 1 person supervision
independent on bed rest transfer- aide (specify)

Ambulation:
2 person 1 person supervision independent crutches
walker (specify type) 2 wheeled walker rollator standard Distance able to walk
_____
Requires wheel chair Yes No

Communication;
Language expression: Intact Basic needs only uses gesturing
Completely impaired
Other barriers to communication:_____

Cognitive Status:
Orientation: Person Place Time Confusion: Mild Moderate Severe
Mini mental score:_____

Behavioral Issues: Physical aggressive or disruptive behavior Verbal aggressive or disruptive behavior other (please specify)_____

Signature :
_____Date:_____