Eastern Health

Adult Rehabilitation,
Palliative Care and Geriatrics

Inpatient Services Referral (Part I)

Name:

HCN:

Date of Birth:

Client Information

Address:_______________ Postal Code:_______________ Age:___ Sex:___ Marital Status: _________

Next of Kin:_______________ Telephone:_______________

Referral Information

Date Referral Completed: DD/MONTH/YYYY Referral Completed by (Name):_______________

Referral Contact:_______________ Telephone:_______________

Referring Physician:_______________ Referring Site and Unit:_______________ Fax:_______________

Has Referral to Rehab Day Services been explored? ☐ Yes ☐ No ☐ N/A

Comments: _______________

Medical Information

Date of Admission: DD/MONTH/YYYY Referring Diagnosis:_______________

Reason for Admission to Acute Care:_______________ Date Diagnosed: DD/MONTH/YYYY

☐ Patient & Family Aware of Diagnosis & Potential for Recovery ☐ Yes ☐ No
☐ Role of Rehab at Dr. L. A. Miller Centre Discussed with Patient ☐ Yes ☐ No
Patient consents to participation in Rehab ☐ Yes ☐ No

Relevant Co-Morbid Conditions/Past Medical History:

(i)_______________
(ii)_______________
(iii)_______________
(iv)_______________

Medical Treatments/Surgical Procedures Since Admission:

(i)_______________
(ii)_______________
(iii)_______________
(iv)_______________

Current Medications (Attach List)

Infection Control

Isolation Precautions: ☐ Yes ☐ No

Type: ☐ MRSA ☐ CDiff ☐ CRO ☐ Other:_______________

Health Status

Allergies: ☐ Yes ☐ No Describe: _______________

Medically Stable: ☐ Yes ☐ No Pending Investigations/Appts:_______________

Ongoing Treatments/Interventions (e.g. Dialysis, Chemotherapy): _______________

Current Blood Work (e.g. Hemoglobin, WBC): _______________

Medically Discharged: ☐ Yes ☐ No Date: DD/MONTH/YYYY
Alpha FIM Score: _______________

Therapy Tolerance Level

☐ Patient has endurance to tolerate 2-4 hours of combined therapy per day

☐ Patient has endurance to tolerate 1 hour of combined therapy per day

☐ Patient tolerates less than 1 hour of combined therapy per day

Comments:_______________

In order to process this Referral – All Parts Must Be Completed. Incomplete referrals will be returned.

Name:_______________ Signature:_______________ Date: DD/MONTH/YYYY

Eastern Health

Adult Rehabilitation,
Palliative Care and Geriatrics

Inpatient Services Referral (Part II)

CL1360 0625 04 2013

Name:

HCN:

Date of Birth:

Bowel	☐ Continent	☐ Commode	☐ Toilet
	☐ Independent with Toileting	☐ One Person Assist	☐ Two Person Assist
	☐ Incontinent	☐ Neurogenic Bowel	Last BM: Date DD/MONTH/YYYY
Bladder	☐ Continent	☐ Commode	☐ Toilet
	☐ Independent with Toileting	☐ One Person Assist	☐ Two Person Assist
	☐ Incontinent	☐ Indwelling Catheter	☐ Neurogenic Bladder
Skin Care	☐ Intact ☐ Open Wound/Ulcer(s) ☐ Burn		
Vision	☐ Adequate ☐ Impaired ☐ Blind ☐ Glasses ☐ Contact Lenses		
Hearing	☐ Adequate ☐ Impaired ☐ Deaf ☐ Use of Hearing Aids		
Sleep	☐ No Difficulty ☐ Disruptive Sleep Pattern ☐ Currently Receiving Sedation		
Presence of Pain	☐ No ☐ Mild ☐ Moderate ☐ Severe Origin of Pain: ____________________		
Safety	☐ Risk for Falls ☐ Physical Restraints ☐ Surveillance ☐ Bed Sensor ☐ Constant Care		
Nutrition	☐ Self-Feed ☐ Partial Assist/Supervision ☐ Complete Feed		
	Special Diet: ____________________		
	Height: ____________________ Weight: ____________________		
Special Needs	☐ Infections (details): ____________________		
	☐ Complex Wound Care/VAC Dressing (details): ____________________		
	☐ Pressure Relieving Mattress (type): ____________________		
	☐ Oxygen (requirements): ____________________		
	☐ CPAP: ____________________		
	☐ Intravenous Therapy (details): ____________________		
	☐ Ostomy (details): ____________________		
	☐ Tube Feeding (requirements): ____________________		
	☐ Dialysis (days of week & times): ____________________		
	☐ Tracheostomy Care (details): ____________________		
	☐ Bariatric Equipment (specify): ____________________		
	Other: ____________________		
Weight Bearing Status	☐ Lower Extremity Status:		
	☐ Full-Weight Bearing ☐ Partial-Weight Bearing ☐ Touch Toe Weight Bearing ☐ Non-Weight Bearing		
	☐ Upper Extremity Restrictions (specify): ____________________		
	Date status to be re-assessed if needed: DD/MONTH/YYYY		

Name:____________________ Signature:____________________ Date: DD/MONTH/YYYY

Eastern Health

Adult Rehabilitation,
Palliative Care and Geriatrics

Inpatient Services Referral (Part III)

CL1360 0625 04 2013

Name:

HCN:

Date of Birth:

Mobility	Lying to Sitting ☐ Independent ☐_____________ Assist x ________ Transfers: ☐ Independent ☐_____________ Assist x ________ Type: ___________ Ambulation: ☐ Independent ☐_____________ Assist x _______________ ☐Non-Ambulatory Gait Aids: ☐ None ☐ Walker ☐ Cane ☐ Crutches ☐ Other: ___________ Stairs: ☐ Not Attempted ☐ Independent ☐ ________Assist x _______ Wheelchair: ☐ Yes ☐ No If yes, type/size:____
Balance	Sitting: ☐ Independent ☐______________ Assist x ________ Standing: ☐ Independent ☐______________ Assist x ______________ Berg Balance Score (If Administered): _____________
Extremities	Limbs: ☐ Normal ☐ Left Sided Impairment ☐ Right Sided Impairment ☐ Bilateral Impairment ☐ Upper Extremity Impairment ☐ Lower Extremity Impairment ☐ Impaired Coordination ☐ Reduced Strength ☐ Other (specify): ____ Details/Other Info:____ ____ ☐ Cast ☐ Splint/Orthotic ☐ Sling Type: ________________________________ Amputation (specify): ☐ TTA ☐ TFA ☐ Bilateral ☐ Other: ______________________ Referral to Prosthetics ☐ Yes ☐ No LEAMS (if administered):_______________
Ability to Bathe	In Bed ☐ Independent ☐ One Person Assist ☐ Two Person Assist Bathtub ☐ Independent ☐ One Person Assist ☐ Two Person Assist
Ability to Dress	Upper Body: ☐ Independent ☐ One Person Assist ☐ Two Person Assist Lower Body: ☐ Independent ☐ One Person Assist ☐ Two Person Assist
Cognitive Function	Oriented to: ☐ Time ☐ Person ☐ Place ☐ Impaired ☐ Delirium Confusion: ☐ Episodic ☐ Frequently Severity is: ☐ Mild ☐ Moderate ☐ Severe Behavioral Issues: Specify:____ Can follow one step/simple commands: ☐ Yes ☐ No Can carryover newly learned information from one session to next: ☐ Yes ☐ No Neuropsychology Consulted: ☐ Yes ☐ No Psychiatry Consulted: ☐ Yes ☐ No Social Interaction: ☐ No difficulty ☐ Mild/Moderate difficulty ☐ Severe difficulty Memory: ☐ No difficulty ☐ Mild/Moderate difficulty ☐ Severe difficulty Mood/Emotion/Affect: ☐ Pleasant/Cooperative ☐ Fearful ☐ Tearful ☐ Anxious ☐ Labile ☐ Withdrawn ☐ Lethargic

Name:______________________ Signature:_______________________ Date: DD/MONTH/YYYY

Eastern Health

Adult Rehabilitation,
Palliative Care and Geriatrics

Inpatient Services Referral (Part IV)

CL1360 0625 04 2013

Name:

HCN:

Date of Birth:

Cognitive Function Continued	Mini-Mental score (if administered): ____ MoCA score (if administered): ____ Geriatric Depression Scale (GDS) - 15 score (if administered): ____

Communication	Communication: ☐ Screened ☐ Assessed ☐ Not Assessed Communication Diagnosis: ____ Swallow: ☐ Screened ☐ Assessed ☐ Not Assessed Swallow Diagnosis: ____ Textures: ____ Date: DD/MONTH/YYYY

Pre-Admission Living Arrangements/Discharge Plan: To be completed by **Social Work/PT/OT/** if possible

☐ Living with spouse/partner ☐ Living alone ☐ Living with family:____ ☐ Other:____

☐ 2 Story House ☐ Bungalow ☐ Apartment ☐ Other:____

☐ Stairs (Inside Residence) Number:____ ☐ (Outside Residence) Number:____ ☐ Ramp

Location of Bedroom: ____ Location of Bathroom: ____

Level of Function Prior to Admission: ____

Adaptive Equipment Currently at Home: ____

Potential Discharge Plan Discussed: ☐Yes ☐ No

Potential Discharge Living Arrangements: ☐ Home Alone ☐ Home with Family/Caregivers ☐ PCH/LTC ☐ Supportive Housing ☐ Home with Renovations ☐ No Plan

Any Concerns Identified: ____

____

Has Social Work Been Consulted? ☐Yes ☐ No Name: ____

Receiving Home Care Prior to Admission: ☐Yes ☐ No Hours per week:____

Funded By: ☐ DVA ☐ Eastern Health ☐ Insurance ☐ Private Pay ☐ Other: ____

If No, is there eligibility for Home Care Services? ☐ Yes ☐ No Source: ____

Please Provide SMART Goals

(i) ____

(ii) ____

(iii)____

(iv)____

Current Therapy: ☐ Occupational Therapy ☐ Physiotherapy ☐ Speech-Language Pathology ☐ Psychology ☐ Social Work ☐ Prosthetics/Orthotics ☐ Clinical Nutrition ☐ Other

Name:____ Signature:____ Date: DD/MONTH/YYYY

Eastern Health

Adult Rehabilitation,
Palliative Care and Geriatrics

Inpatient Services Referral (Part V)

CL1360 0625 04 2013

Name:

HCN:

Date of Birth:

Indicate below, in your professional opinion is this patient a good candidate for inpatient rehab? Why/Why Not?

NURSING:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________

OCCUPATIONAL THERAPY:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________

PHYSIOTHERAPY:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________

PSYCHOLOGY:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________

Eastern Health

Adult Rehabilitation,
Palliative Care and Geriatrics

Inpatient Services Referral (Part VI)

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Name:

HCN:

Date of Birth:

SOCIAL WORK:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________

SPEECH-LANGUAGE PATHOLOGY:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________

OTHER:

Name:____________________ Signature:_____________________ Date:_DD/MONTH/YYYY_ Telephone/Pager:_________________