



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@hrsrh.on.ca or Andrea Lee, Chair, alee@hrsrh.on.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 <input type="checkbox"/> M <input type="checkbox"/> F	Health Card #:
Postal Code:	Home Phone:	Marital Status:	
Language(s) spoken: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (Specify):		Referring Institution:	
Contact Person for Clinical Information:		Phone #:	Pager #:
Contact Person for Bed Offer: <input type="checkbox"/> Same as above OR:		Phone #:	Pager #:
Infections: <input type="checkbox"/> MRSA+ <input type="checkbox"/> VRE+ <input type="checkbox"/> CDIFF <input type="checkbox"/> None Known <input type="checkbox"/> Other (Specify):			
Isolation Required: <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (Details):			
Past Medical History:			
Social Information			
Home living situation, living with: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Living Alone <input type="checkbox"/> Family (incl. extended family) <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Unknown		Support required before admission to acute care: <input type="checkbox"/> None <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Family (incl. extended family) <input type="checkbox"/> Roommate or Others <input type="checkbox"/> Attendant care <input type="checkbox"/> CCAC <input type="checkbox"/> Privately-funded care <input type="checkbox"/> Unknown <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Other (Specify):	
Pre-Admission Accommodation: <input type="checkbox"/> House <input type="checkbox"/> Residential Group Home <input type="checkbox"/> Apartment Building <input type="checkbox"/> Retirement Home <input type="checkbox"/> Long-term Care Home <input type="checkbox"/> Rooming House <input type="checkbox"/> Homeless/Hostel <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify):		Describe accommodation barriers that must be dealt with in order for patient to return home: <input type="checkbox"/> No barriers <input type="checkbox"/> Stairs to bedroom <input type="checkbox"/> Stairs into dwelling <input type="checkbox"/> Other (list): <input type="checkbox"/> Stairs to bathroom	
Expected discharge destination post rehab: <input type="checkbox"/> Home <input type="checkbox"/> LTC <input type="checkbox"/> CCC <input type="checkbox"/> Shelter/Hostel <input type="checkbox"/> Assisted Living (i.e. senior's residence): <input type="checkbox"/> Return to Referring Facility: <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes Have back-up plans been discussed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify:			



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Contenance

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: <input type="checkbox"/> New <input type="checkbox"/> Chronic <input type="checkbox"/> Not Applicable	If new, has a swallowing assessment been completed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please attach report
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Method of Intake: ORAL PEG NG NPO Other (Details):

Coughing/Throat Clearing while eating: <input type="checkbox"/> No <input type="checkbox"/> Yes	History of Pneumonia: <input type="checkbox"/> No <input type="checkbox"/> Yes (When)
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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:
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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:



Inpatient Rehabilitation Referral Form

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:



Inpatient Rehabilitation Referral Form

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: <input type="checkbox"/> No <input type="checkbox"/> Yes						
If yes, has change in medical status been reported to the Ministry of Transportation: <input type="checkbox"/> No <input type="checkbox"/> Yes						
Employment status/Occupation:						
Goals						
Patients Goals:						
Have the goals been discussed with the patient: <input type="checkbox"/> No <input type="checkbox"/> Yes						
Progress/Participation						
Please outline patient progress to date:						
Patient receives therapies?: <input type="checkbox"/> No <input type="checkbox"/> 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?: <input type="checkbox"/> No <input type="checkbox"/> Yes						
Can he/she remember the activity between sessions? <input type="checkbox"/> No <input type="checkbox"/> Yes If No, (Details):						
Other Comments/Issues						
Is the patient willing /motivated to participate at a rehabilitation centre outside of town: <input type="checkbox"/> No <input type="checkbox"/> 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:

- 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:	
<p>Hôpital régional de Sudbury Regional Hospital Colleen Bronicheski, RN Clinical Manager, Intensive Rehab Unit Fax (705) 523-7091</p> <p>Sault Area Hospital Sue Hamel-LaFord, RN Manager, Complex Continuing Care, In Patient Rehab and TCU Fax (705) 759-3458</p> <p>Timmins and District Hospital Donna Gravel, BSW, RSW Social Work/Discharge Planning, Rehabilitation/Complex Continuing Care/Interim LTC Fax (705) 267-6308</p>	<p>North Bay General Hospital Terry Murray-Maeck, SW Social Worker/Discharge Planner, Rehabilitation Unit Fax (705) 495-0788</p> <p>West Parry Sound Health Centre Cathy Hennigar, RN Discharge Planner Fax (705) 773-4054</p>

Internal Office Use: Videoconference required? No Yes

Patient Surname: