Acute Care to Rehab & Complex Continuing Care (CCC) Referral

Insert Health Service Provider Logo

Identify Referral Destination: ☐ *Referral to Rehab*

☐ *Referral to Complex Continuing Care (CCC)*

Patient Identification

If Faxed Include Number of Pages (Including Cover): **Pages**

Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY

Patient Details and Demographics

Health Card #: Version Code: Province Issuing Health Card:

No Health Card #: ☐ No Version Code: ☐

Surname: Given Name(s):

No Known Address: ☐

Home Address: City: Province:

Postal Code: Country: Telephone: Alternate Telephone:

No Alternate Telephone: ☐

Current Place of Residence (Complete If Different From Home Address):

Date of Birth: DD/MM/YYYY Gender: ◯ M ◯ F ◯ Other Marital Status:

In which of the two official languages is the patient most comfortable receiving health services? ◯ English ◯ French

What is the patient's mother tongue? ◯ English ◯ French ◯ Other Interpreter Required: ◯ Yes ◯ No

Primary Alternate Contact Person:

Relationship to Patient(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Secondary Alternate Contact Person: None Provided: ☐

Relationship to Patient(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Insurance: N/A: ☐

Current Location Name: Current Location Address: City:

Province: Postal Code:

Current Location Contact Number: Bed Offer Contact (Name): Bed Offer Contact Number:

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Patient Identification

Medical Information

Primary Health Care Provider (e.g. MD or NP) Surname: Given Name(s):

☐ None

Reason for Referral:

Allergies: ◯ No Known Allergies ◯ Yes --- If Yes, List Allergies:

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify):

Admission Date: DD/MM/YYYY Date of Injury/Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Rehab Specific Patient Goals:

CCC Specific Patient Goals:

Nature/Type of Injury/Event:

Primary Diagnosis:

History of Presenting Illness/Course in Hospital:

Current Active Medical Issues/Medical Services Following Patient:

Past Medical History:

Height: Weight:

Is Patient Currently Receiving Dialysis: ◯ Yes ◯ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days:

Location:

Is Patient Currently Receiving Chemotherapy: ◯ Yes ◯ No Frequency: Duration:

Location:

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Is Patient Currently Receiving Radiation Therapy: ◯ Yes ◯ No Frequency: Duration:

Location:

Concurrent Treatment Requirements Off-Site: ◯ Yes ◯ No Details:

CCC Specific

Medical Prognosis: ◯ Improve ◯ Remain Stable ◯ Deteriorate ◯ Palliative ◯ Unknown Palliative Performance Scale:

Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other

Pending Investigations: ◯ Yes ◯ No Details:

Frequency of Lab Tests: ☐ Unknown ☐ None

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements?: ◯ Yes ◯ No -- If No, Skip to Next Section

Supplemental Oxygen: ◯ Yes ◯ No Ventilator: ◯ Yes ◯ No

Breath Stacking: ◯ Yes ◯ No Insufflation/Exsufflation: ◯ Yes ◯ No

Tracheostomy: ◯ Yes ◯ No ◯ Cuffed ◯ Cuffless

Suctioning: ◯ Yes ◯ No Frequency:

C-PAP: ◯ Yes ◯ No Patient Owned: ◯ Yes ◯ No

Bi-PAP: ◯ Yes ◯ No Rescue Rate: ◯ Yes ◯ No Patient Owned: ◯ Yes ◯ No

Additional Comments:

IV Therapy

IV in Use?: ◯ Yes ◯ No -- If No, Skip to Next Section

IV Therapy: ◯ Yes ◯ No Central Line: ◯ Yes ◯ No PICC Line : ◯ Yes ◯ No

Swallowing and Nutrition

Swallowing Deficit: ◯ Yes ◯ No Swallowing Assessment Completed: ◯ Yes ◯ No

Type of Swallowing Deficit Including any Additional Details:

TPN: ◯ Yes (If Yes, Include Prescription With Referral) ◯ No

Enteral Feeding: ◯ Yes ◯ No

Please Include Any Special Diet Concerns:

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Skin Condition

Surgical Wounds and/or Other Wounds Ulcers: ◯ Yes ◯ No -- If No, Skip to Next Section

1. Location: Stage:

Dressing Type: Frequency:

(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ◯ Less Than 30 Minutes ◯ Greater Than 30 Minutes

2. Location: Stage:

Dressing Type:

(e.g. Negative Pressure Wound Therapy or VAC) Frequency:

Time to Complete Dressing: ◯ Less Than 30 Minutes ◯ Greater Than 30 Minutes

3. Location: Stage:

Dressing Type:

(e.g. Negative Pressure Wound Therapy or VAC) Frequency:

Time to Complete Dressing: ◯ Less Than 30 Minutes ◯ Greater Than 30 Minutes

* ***If additional wounds exist, add supplementary information on a separate sheet of paper.***

Continence

Is Patient Continent?: ◯ Yes ◯ No -- If Yes, Skip to Next Section

Bladder Continent: ◯ Yes ◯ No If No: ☐ Occasional Incontinence ☐ Incontinent

Bowel Continent: ◯ Yes ◯ No If No: ☐ Occasional Incontinence ☐ Incontinent

Pain Care Requirements

Does the Patient Have a Pain Management Strategy?: ◯ Yes ◯ No -- If No, Skip to Next Section

Controlled With Oral Analgesics: ◯ Yes ◯ No

Medication Pump: ◯ Yes ◯ No

Epidural: ◯ Yes ◯ No

Has a Pain Plan of Care Been Started: ◯ Yes ◯ No

Communication

Does the Patient Have a Communication Impairment?: ◯ Yes ◯ No -- If No, Skip to Next Section

Communication Impairment Description:

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Patient Identification

Cognition

Cognitive Impairment: ◯ Yes ◯ No ◯ Unable to Assess -- If No, or Unable to Assess, Skip to Next Section

Details on Cognitive Deficits:

Has the Patient Shown the Ability to Learn and Retain Information: ◯ Yes ◯ No -- If No, Details:

Delirium: ◯ Yes ◯ No -- If Yes, Cause/Details:

History of Diagnosed Dementia: ◯ Yes ◯ No

Behaviour

Are There Behavioural Issues: ◯ Yes ◯ No -- If No, Skip to Next Section

Does the Patient Have a Behaviour Management Strategy?: ◯ Yes ◯ No

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering

☐ Sun downing ☐ Exit-Seeking ☐ Resisting Care ☐ Other

☐ Restraints -- If Yes, Type/Frequency Details :

Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one

Social History

Discharge Destination: ◯ Multi-Storey ◯ Bungalow ◯ Apartment ◯ LTC

◯ Retirement Home (Name):

Accommodation Barriers: ☐ Unknown

Smoking: ◯ Yes ◯ No Details:

Alcohol and/or Drug Use: ◯ Yes ◯ No Details:

Previous Community Supports: ◯ Yes ◯ No Details:

Discharge Planning Post Hospitalization Addressed: ◯ Yes ◯ No Details:

Discharge Plan Discussed With Patient/SDM: ◯ Yes ◯ No

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Current Functional Status

Sitting Tolerance: ◯ More Than 2 Hours Daily ◯ 1-2 Hours Daily ◯ Less Than 1 Hour Daily ◯ Has not Been Up

Transfers: ◯ Independent ◯ Supervision ◯ Assist x1 ◯ Assist x2 ◯ Mechanical Lift

Ambulation: ◯ Independent ◯ Supervision ◯ Assist x1 ◯ Assist x2 ◯ Unable

Number of Metres:

Weight Bearing Status: ◯ Full ◯ As Tolerated ◯ Partial ◯ Toe Touch ◯ Non

Bed Mobility: ◯ Independent ◯ Supervision ◯ Assist x1 ◯ Assist x2

Activities of Daily Living

Level of Function Prior to Hospital Admission (ADL & IADL) :

Current Status – Complete the Table Below:

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)	◯	◯	◯	◯	◯	◯

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Special Equipment Needs

Special Equipment Required: ◯ Yes ◯ No -- If No, Skip to Next Section

☐ HALO ☐ Orthosis ☐ Bariatric ☐ Other

Pleuracentesis: ◯ Yes ◯ No	Need for a Specialized Mattress: ◯ Yes ◯ No
Paracentesis: ◯ Yes ◯ No	Negative Pressure Wound Therapy (NPWT): ◯ Yes ◯ No

Rehab Specific
AlphaFIM® Instrument

Is AlphaFIM® Data Available: ◯ Yes ◯ No -- If No, Skip to Next Section

Has the Patient Been Observed Walking 150 Feet or More: ◯ Yes ◯ No

If Yes – Raw Ratings (levels 1-7):	Transfers: Bed, Chair	Expression	Transfers: Toilet
	Bowel Management	Locomotion: Walk	Memory
If No – Raw Ratings (levels 1-7):	Eating	Expression	Transfers: Toilet
	Bowel Management	Grooming	Memory
Projected:	FIM® projected Raw Motor (13):	FIM® projected Cognitive (5):	
	Help Needed:		

Attachments

Details on Other Relevant Information That Would Assist With This Referral:

Please Include With This Referral:

- ☐ Admission History and Physical
- ☐ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician)
- ☐ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.)
- ☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)

Completed By: **Title:** **Date:** DD/MM/YYYY

Contact Number: **Direct Unit Phone Number:**