Patient Identification

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

Identify Referral Destination:

- ☐ *Referral to Rehabilitative Care*
  - ☐ *Rehabilitation*
  - ☐ *Stroke Rehabilitation*
- ☐ *Referral to Complex Continuing Care (CCC)*
  - ☐ *Behavioural Health*
  - ☐ *Palliation*
  - ☐ *Activation / Restoration*
  - ☐ *Long Term Medically Complex*
  - ☐ *Short Term Medically Complex*

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

Patient Details and Demographics		
Health Card #: No Health Card #: ☐	Version Code: No Version Code: ☐	Province Issuing Health Card:
Surname:	Given Name(s):	
No Known Address: ☐	Home Address:	City:
Province: Postal Code:	Country:	Telephone #:
No Alternate Telephone: ☐		Alternate Telephone #:
Current Location Name:	Current Location Address:	City:
Province:	Postal Code:	
Current Location Contact Number:	Bed Offer Contact (Name):	Bed Offer Contact Number:

Medical Information
Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐TB ☐ CPE ☐ Other (Specify):____________________
<u>Rehab Specific</u> Patient Goals *(Include proposed plans including, discharge plan, discharge destination, discharge care, etc.)*: Weight Bearing Status: Prosthesis: ☐Yes ☐No ☐Patient and/or family aware of plan and timelines
<u>CCC Specific</u> Patient Goals (*Include proposed plans including, discharge plan, discharge destination, discharge care, etc.)*: ☐ Patient and/or family aware of plan and timelines
Is Patient Currently Receiving Dialysis: ☐Yes ☐No ☐Peritoneal ☐Hemodialysis Frequency/Days: Location:__________ ________
Is the Patient Receiving Chemotherapy: ☐ Yes ☐ No Frequency: Duration: Location:_____________________

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Services Involved: ☐PT ☐OT ☐SW ☐SLP ☐Dietitian ☐Other:_______

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements? ☐ Yes ☐ No If Yes, explain:

Swallowing and Nutrition

TPN: ☐ Yes (If Yes, Include Prescription with Referral) ☐ No

Enteral Feeds: ☐ Yes ☐ No

Skin Condition

Surgical Wounds and/or Other Wounds, Ulcers: ☐ Yes ☐ No – If Yes, explain:

Date of Injury/Surgery:

Cognition

Has the Patient Shown the Ability to Learn and Retain Information? ☐ Yes ☐ No – If No, explain:

Behaviour

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation
☐ Wandering ☐ Sun Downing ☐ Exit Seeking ☐ Resisting Behaviour
☐ Delerium ☐ Other

☐ Restraints – If Yes, Type/Frequency Details:

Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No – If No, Skip Section

☐ HALO ☐ Orthosis ☐ Bariatric ☐ Other:_____________________

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

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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: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						

Attachments

Details on other relevant information that would assist with this referral:

Please Include With This Referral:

- ☐ Admission History and Physical
- ☐ Relevant Assessments (Behavioural, PR, 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
- ☐ For Stroke, Include AlphaFIM

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