Inpatient Rehab/CCC Referral Form*

The ***Inpatient Rehab/CCC Referral Form*** is to be used for referrals to inpatient rehabilitation or Complex Continuing Care (CCC) offered by the GTA Rehab Network member organizations.

This referral package is to be used for all rehab and CCC referrals ***except:***

- Elective Total Joint Replacements and uncomplicated Elective Cardiac Bypass/Valve Surgery (Streamlined referral process already in place)
- Palliative Care
- E-Stroke - Referrals are to be made through the electronic E-Stroke Rehab Referral System. For those organizations that do not have access to the E-Stroke Rehab Referral System, please download the PDF version of the E-Stroke Rehab Referral form from the GTA Rehab Network's website at: http://www.gtarehabnetwork.ca/inpatient-rehab-ccc .
- Referrals for Geriatric Psychiatry at Toronto Rehab are to be made using Toronto Rehab's existing application form.

IMPORTANT: **For each referral, please complete the following and FAX DIRECTLY TO THE PROGRAMS/ORGANIZATIONS YOU ARE REQUESTING. Do not fax your referral to the GTA Rehab Network.**

EXCEPTION: **All ABI referrals should be faxed directly to the Toronto ABI Network (416) 597-7021.**

For each referral, please complete the following and fax directly to the programs you are requesting:

1. *Acute Care to Inpatient Referral Form*: (includes Demographic, Referral, Social, Acute Care Medical Assessment, Care Requirements and Consent sections)
2. A *functional form* relevant to the rehab population being referred. Please use your clinical judgment to determine which functional would be most appropriate to give the best clinical picture of the patient. For example, the geriatric functional may be more appropriate to describe the functional needs of an older patient referred for MSK rehab.
3. For CCC referrals (other than referrals for Low Tolerance Long Duration / slow stream rehab), please complete the *CCC functional form.*

Attachments required:

✓ Medication list
✓ Abnormal CT Scan results
✓ Chemotherapy protocol, lab monitoring requirements, clinical impacts (oncology patients only)

Optional attachments:

✓ Social Work report
✓ Behavioural supplemental information

Sending of Updates:
For the majority of referrals, the sending of updates is not needed. However, in the event that there is any *significant* change/deterioration in the patient's status (i.e. medical, functional, infection status and or equipment needs), notify the inpatient rehab/CCC facility via telephone and/or by faxing medical notes and/or OT/PT/SLP notes.

Discharge/Transfer Checklist:
Upon transfer of patient, please refer to the ***Discharge/Transfer Checklist*** regarding the information that is to be sent with the patient to the post-acute destination.

*Copies of the Inpatient Rehab/CCC Referral Form can be downloaded from the GTA Rehab Network's website at http://www.gtarehabnetwork.ca/inpatient-rehab-ccc.

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 1: DEMOGRAPHIC INFORMATION
To be completed by Social Worker/Discharge Planner/Case Manager

INPATIENT REHAB/CCC REFERRAL

Please complete the Inpatient Rehab/CCC Referral Form ***and*** a population-specific functional form. Send the completed copies via fax to the program requested.

PATIENT REGISTRATION

Patient's first name		**Last name**	
Sex ☐ M ☐ F		**DOB** (YYYY-MM-DD)	
Health Card Number	**Version**	**Expiry Date (If available)**	**Province/Territory issuing Health Card** ☐ 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			
Speaks, understands English ☐ Yes ☐ No ☐ Minimal		Interpreter Needed? ☐ Yes ☐ No	
Speaks, understands another language (list)			
Other relevant cultural considerations (specify)			

EMERGENCY CONTACT

Relationship to patient: ☐Spouse ☐ Partner ☐ Son/Daughter ☐ Sibling ☐ Parent ☐ Relative ☐ Friend ☐ Other (specify):_____

Is the Emergency Contact a substitute decision-maker? ☐ Yes ☐ No

Name:

Address:	City/Prov:	Postal Code:
Daytime Phone:	Evening Phone:	

RESPONSIBILITY FOR PAYMENT *Source; CIHI NRS*

☐ OHIP	☐ Federal Government	☐ IFH (Interim Federal Health Grant)
☐ Inter-provincial Insurance Plan	☐ Insured/Self Pay	☐ Other Payment Sources
☐ WSIB	☐ Uninsured/Self Pay	☐ Unknown

If insurance payment

Name of insurer _____ Claim # _____ Certificate #_____

Group Number _____ Policy # _____

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

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 2: REFERRAL INFORMATION

To be completed by Social Worker/Discharge Planner/Case Manager

Patient's Name	
Patient's admission date to this facility (YYYY-MM-DD)	**Attending Physician**
Referring facility	
Program Name and Service	
Bed Offer Contact (name and number/pager)	**Fax number**
Primary Contact ☐ Same as above. If different, specify name, number/pager and fax number.	
Date Referral Completed (YYYY-MM-DD)	
Anticipated date ready for rehab[1] or ready for transfer to rehab/CCC (YYYY-MM-DD)	
If early referral (e.g., patient to be weaned off of NG tube, IV to be taken out) specify if special needs are expected to resolve. **Comment**	

Inpatient setting type requested

☐ Rehab: High Tolerance/Regular stream
☐ Rehab: Low Tolerance Long Duration (LTLD/slowstream)
☐ Complex Continuing Care (CCC)

Rehab/CCC population requested

☐ ABI ☐ Amputee ☐ Burns ☐ Cardiac
☐ Chronic Ventilation ☐ General/Medical ☐ Geriatric ☐ MSK
☐ Neuro ☐ Oncology ☐ Respiratory Rehab
☐ Spinal Cord ☐ Trauma ☐ Transplant
☐ Other_____

Organizations referred to: (Rank client preference in check boxes)

___ Baycrest
___ Bridgepoint Health
___ Credit Valley Hospital
___ Halton Healthcare Services
___ Lakeridge Health
___ Markham Stouffville Hospital
___ Providence Healthcare
___ Rouge Valley Health System
___ Runnymede Healthcare Centre
___ Southlake Regional Health Centre
___ St. John's Rehab Hospital
___ Toronto East General Hospital
___ Toronto Grace Health Centre
___ Toronto Rehab
___ Trillium Health Centre
___ West Park Healthcare Centre
___ William Osler Health Centre
___ York Central Hospital
___ Other (specify):_____

Preferred accommodation

☐ Ward ☐ Semi private ☐ Private ☐ Isolation ☐ Other (specify): _____
☐ Co-payment fees reviewed (where appropriate)

Additional referral comments

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

[1] Ready for rehab: Refer to Inpatient Rehab/LTLD Referral Guidelines GTA Rehab Network 2009, http://www.gtarehabnetwork.ca/referral-guidelines

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 3: SOCIAL INFORMATION

To be completed by Social Worker

Patient's Name:

PERSONAL CARE	FINANCES
Who manages the patient's PERSONAL CARE decisions now? ☐ Self ☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian ☐ Public Guardian/Trustee ☐ Others ☐ Don't know **If other than Self, list contact information, PERSONAL CARE** Name: _____ Relationship to patient: ☐Spouse ☐ Partner ☐ Son/Daughter ☐ Sibling ☐ Parent ☐ Relative ☐ Friend ☐ Appointed ☐ Other	**Who manages the patient's FINANCES now?** ☐ Same as contact person, PERSONAL CARE **or** ☐ Self ☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian ☐ Public Guardian/Trustee ☐ Others ☐ Don't know **If other than Self or Personal Care decision maker, list Contact Person and contact information, FINANCES** Name: _____ Relationship to patient: ☐Spouse ☐ Partner ☐ Son/Daughter ☐ Sibling ☐ Parent ☐ Relative ☐ Friend ☐ Appointed ☐ Other
Address: City/Prov: Postal Code:	Address: City/Prov: Postal Code:
Daytime Phone: Evening Phone:	Daytime Phone: Evening Phone:
Financial Information: (*Adapted from CIHI NRS)* ☐ WSIB ☐ EI ☐ STD ☐ LTD ☐ CPP ☐ OAS ☐ ODSP ☐ Ontario Works ☐ Self-Employed ☐ Employed ☐ Veteran ☐ No income ☐ Auto Insurance *(provide name of insurance co., adjustor):*	**Marital Status:** ☐ Single ☐ Separated ☐ Unknown ☐ Married ☐ Divorced ☐ Common Law ☐ Widowed
Home living situation, living with: *(Adapted from CIHI-NRS)* ☐ Spouse/Partner ☐ Living Alone ☐ Family (including extended family) ☐ Not applicable ☐ Others ☐ Unknown	**Support required before admission to acute care:** ☐ None ☐ Spouse/Partner ☐ Family support (including extended family) ☐ Roommate or others ☐ Attendant care ☐ CCAC ☐ Privately-funded care ☐ Other (Specify):
Pre-Admission Accommodation: ☐ House ☐ Long-term Care Home ☐ Homeless/Hostel ☐ Apartment Building ☐ Rooming House ☐ Unknown ☐ Retirement Home ☐ Residential Group Home ☐ 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 ☐ Don't know ☐ Stairs to bathroom ☐ Other (list):
Caregiver support post-rehab can be provided by: (Check all that apply) ☐ None ☐ Spouse/Partner ☐ Family support (including extended family) ☐ Roommate or Others ☐ Attendant care ☐ CCAC ☐ Privately-funded care ☐ Other (Specify):	**Expected discharge destination post rehab:** ☐ Home ☐ LTC ☐ CCC ☐ Assisted Living (e.g. seniors building) ☐ Shelter/Hostel ☐ Don't know ☐ Other (specify) Has discharge plan been discussed with client/family? ☐ Yes ☐ No Have back-up plans been discussed? ☐ No ☐ Yes If yes, specify:

Comments regarding social situation/issues: ☐ Social Work Report Attached

Completed by:	Telephone:	Date:

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 4: ACUTE CARE MEDICAL ASSESSMENT

To be completed by Physician or Physician Designate

Patient's Name: _____

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, orthopaedic 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? ☐ No ☐ Yes If yes, please specify drug(s), availability and costs:

_____

_____

_____

Weight bearing status: ☐ No restrictions

Left: ☐ As tolerated ☐ Partial_____lbs ☐ Touch weight bearing ☐ Non weight bearing.
Precautions and restrictions: _____ Date to become weight bearing: _____

Right: ☐ As tolerated ☐ Partial_____lbs ☐ Touch weight bearing ☐ Non weight bearing.
Precautions and restrictions: _____ Date to become weight bearing: _____

For Oncology Patients only:

Summary of current cancer picture: ☐ Radiotherapy Specify start date, duration & frequency: _____

☐ Chemotherapy (Specify): ☐ Oral ☐ IV ☐ Other (Attach protocol, lab monitoring requirements, anticipated side effects and other clinical impacts.)

Haemoglobin and White Blood Cell Count done within last week? ☐ Yes ☐ No **Results:** _____

Have end of life care issues been discussed with: Patient? ☐Yes ☐ No Family? ☐ Yes ☐ No ☐ N/A

Please specify any issues/concerns: _____

_____

Referring Physician/Designate: I authorize a referral for this individual for the hospital/agency/program specified.

Name: _____ Phone: ( ) _____ Signature: _____ Date: _____

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 5: CARE REQUIREMENTS

To be completed by Nursing

Patient's Name:

Smoker: ☐ No ☐ Yes ☐ Independent/Safe

Weight: ☐ 300 lbs (136 Kg) or more

Height: _____ ☐ Inches ☐ Centimetres ☐ 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 ☐ Kosher ☐ Diabetic ☐ Renal ☐ Low Sodium ☐ Other (specify):

Fully Oriented? ☐ Yes ☐ No If no, specify below:

Oriented to: ☐ Person ☐ Place ☐ Time

Comments:

Behavioural Issues: ☐ No ☐ Yes If yes, please describe or ✓ if supplemental information attached ☐ (For ABI patients, see ABI functional section for more information.)

Infection Control - Does individual currently have:

MRSA: ☐ No ☐ Yes Location: _____ VRE: ☐ No ☐ Yes Location: _____

C-Difficile: ☐ No ☐ Yes Other: (Specify) _____

Safety Support required:

☐ N/A ☐ Requires bed rails ☐ Requires Geri chair ☐ Requires Hoyer/Mechanical lift

Wandering risk:

☐ N/A ☐ Indoor ☐ Outdoor ☐ Wander guard ☐ Exit Seeker

Restraints used:

☐ N/A ☐ Physical ☐ Chemical ☐ Lap belt

☐ Wrist restraint ☐ One-to-one ☐ Other

Reason:

☐ Exit-seeking, at risk 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):

SPECIAL NEEDS: Indicate the special needs of the patient.

Tracheostomy: ☐ N/A ☐ Cuffed ☐ Uncuffed

Size: _____ Brand _____

Frequency of suctioning _____

Intravenous: ☐ N/A ☐ Central Line ☐ Peripheral Line

☐ Portacath ☐ Other_____

Oxygen: ☐ N/A

☐ Intermittent Oxygen _____ L/min ☐ Constant Oxygen _____L/min

☐ 02 at rest _____ L/min ☐ 02 at exercise_____ L/min☐

BIPAP ☐ CPAP

Enteral Feeding: ☐ N/A

☐ NG Tube ☐ GJ Tube ☐ J Tube ☐ G Tube

Specify type & rate of feeds:

Dialysis: ☐ N/A ☐ Peritoneal Dialysis ☐ Hemodialysis

Accessibility to Dialysis Centres: ☐ Family drives ☐ Volunteer drives ☐ Wheel-Trans ☐ Other_____

Treatment Dates/Times/Location (specify):

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 5: CARE REQUIREMENTS (cont'd)

To be completed by Nursing

Patient's Name:

Ventilation: ☐ N/A ☐ Chest Tube
☐ Ventilation Specify type of vent:

Skin condition: ☐ Intact ☐ Not intact ☐ One Site ☐ Multiple Sites ☐ Vac Therapy ☐ Burn

Location

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:**

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 6: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager)**:**

☐ I agree that _____
(Name of facility disclosing information)

may release my personal health information to make a referral.

Organizations referred to:

___ Baycrest
___ Bridgepoint Health
___ Credit Valley Hospital
___ Halton Healthcare Services
___ Lakeridge Health
___ Markham Stouffville Hospital
___ Providence Healthcare
___ Rouge Valley Health System
___ Runnymede Healthcare Centre
___ St. John's Rehab Hospital
___ St. John's Rehab Hospital
___ Toronto East General Hospital
___ Toronto Grace Health Centre
___ Toronto Rehab/UHN
___ Trillium Health Centre
___ West Park Healthcare Centre
___ William Osler Health Centre
___ York Central Hospital
___ Other (specify): _____

To be completed for all referrals:

Print Name of Patient: _____

Signature of Patient/Substitute: _____ Date:(YYYY/MM/DD)_____

Name of Substitute: _____
(print name)

Relationship to patient, if signed by Substitute: _____

☐ Yes, an interpreter was used when consent was obtained.

☐ No interpreter was required.