Toronto Stroke Rehab Referral System

ACUTE CARE TO INPATIENT REHAB REFERRAL FORM

INPATIENT REHAB REFERRALS:
Please complete all fields and send referral electronically through **E Stroke** or fax a copy of this form to the stroke rehab program if outside of Toronto.

1. PATIENT REGISTRATION

Patient's first name	**Last Name**	
Patient's gender ☐ M ☐ F	**Patient's DOB**	**YYYY-MM-DD**
Health Card Number *	**Version**	**Expiry Date**
Province/Territory Issuing Health Card	**Referral Provider**	

2. DEMOGRAPHICS

Patient's 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)				
Premorbid Vocational Status (before this encounter) (amended from CIHI-NRS)				
☐ Full time or 30 hrs/week	☐ Part-time <30 hrs/week	☐ Adjusted/modified work	☐ Student	☐ Volunteer
☐ Retired	☐ Self-employed	☐ Unemployed	☐ Homemaker	☐ Don't know
Type of vocation				
Educational Level (choose HIGHEST level completed)				
☐ High School Grade 12	☐ High School Grade 13	☐ College Diploma	☐ University Degree	
☐ Masters Degree	☐ Doctoral Degree	☐ Don't know	☐ Other (list)	

3. ACUTE CARE MEDICAL ASSESSMENT: STROKE EVENT

Dear Physician or Physician Designate,
You have been asked, to complete this Medical Assessment.
*** All fields must be completed.**

Patient's Name	
Date of Stroke Onset (or Date Last Seen Normal) *	**YYYY-MM-DD**
First Stroke? * ☐ **Yes** ☐ **No**	**Date Previous Stroke** **YYYY-MM-DD**
Deficits Previous Stroke	
Type of Stroke* (current stroke)	☐ Ischemic ☐ Hemorrhagic ☐ Transforming to Hemorrhagic
Stroke Location (most recent CT/MRI)	☐ Left ☐ Right ☐ Frontal ☐ Parietal ☐ Occipital ☐ Temporal ☐ Internal Capsule ☐ Basal ganglia ☐ Thalamus ☐ Cerebellum ☐ Brainstem
Mechanism of Stroke	☐ Carotid Stenosis Required Surgery? ☐ Yes ☐ No ☐ Cardioembolic ☐ Atrial Fibrillation ☐ Dilated Cardiomyopathy or other structural/wall movement abnormality ☐ Valvular problem ☐ Dissection ☐ Carotid ☐ Vertebral ☐ Small Vessel Thrombosis ☐ Auto Immune ☐ Unknown ☐ Other (Provide details) .....
Deficits Current Stroke ☐ L Hemiparesis ☐ R Hemiparesis ☐ No Paresis ☐ Aphasia ☐ Dysphagia ☐ Apraxia ☐ Sensory Neglect ☐ Ataxia ☐ Other (provide details):	
Old/Chronic CT or MRI Findings	☐ None ☐ Evidence of previous infarcts ☐ Sub cortical white matter changes - Mild ☐ Sub cortical white matter changes - Moderate ☐ Sub cortical white matter changes - Severe
Stroke Workup **Echocardiogram** ☐ Done ☐ Not indicated ☐ Booked ____/__/__ yy/mm/dd **Holter Monitor** ☐ Done ☐ Not indicated ☐ Booked ____/__/__ yy/mm/dd **Carotid Imaging** ☐ Done ☐ Not indicated ☐ Booked ____/__/__ yy/mm/dd **Secondary Prevention Clinic** ☐ Booked ____/__/__ yyyy/mm/dd ☐ Referred ☐ Not Required	

* Electronic Referral cannot be made without completion of this field

3. ACUTE CARE MEDICAL ASSESSMENT: STROKE EVENT (cont)

Patients Name

Specific conditions impacting on rehab potential

☐ **None on this list**

☐ Angina
☐ Coronary Artery bypass Surgery or Stenting procedure
☐ Atrial Fibrillation
☐ Arthritis
☐ Osteoporosis
☐ Amputation
☐ Asthma
☐ Systemic Lupus Erythematosis
☐ Cerebral Vasculitis
☐ Other (list): .....

Charleson Comorbidities Index

☐ No comorbidities on **THIS** list

☐(1) Myocardial Infarct
☐(1) Congestive Heart failure
☐(1) Peripheral Vascular disease
☐(1) Cerebrovascular disease
☐(1) Dementia
☐(1) Chronic pulmonary disease
☐(1) Connective tissue disease
☐(1) Ulcer
☐(1) Mild liver disease
☐(1) Diabetes
☐(2) Hemiplegia (Pre-existing)
☐(2) Moderate or severe renal disease
☐(2) Diabetes with end organ damage
☐(2) Any tumor
☐(2) Leukemia
☐(2) Lymphoma
☐(3) Moderate or severe liver disease
☐(3) AIDS

The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores > 3 may not tolerate rehabilitation

☐ **Other Comorbid Conditions of Significance** (list): .....

Previous psychiatric history * **No** ☐ **Yes** ☐ **If Yes describe history and status**

_____

Current psychiatric diagnosis * **No** ☐ **Yes** ☐ **if Yes specify diagnosis and status**

_____

Surgical History ☐ **No surgeries**

List surgeries during this hospitalization with date: _____

Complications resulting from surgery: _____

Referring Physician's Name **Date** YYYY-MM-DD

Attending Physician's Name

4. EPISODE INFORMATION

Patient's Name	**MRN/Chart Number**
Patient's admission date to this facility	**YYYY-MM-DD**

FINANCES

Who manages the patient's FINANCES now? ☐ Self ☐ Others ☐ Don't Know

If OTHERS, list contact information contact person, FINANCES
Name
Relationship to patient ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other

Address	Postal Code
Daytime Phone	Evening Phone

PERSONAL CARE

Who manages the patient's PERSONAL CARE decisions now? ☐ Self ☐ Others

If others, list contact information ☐Same as contact person, **FINANCES OR**

Contact Person, PERSONAL CARE decisions
Name
Relationship to patient ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other

Address	Postal Code
Daytime Phone	Evening Phone

SUBSTITUTE DECISION MAKER

Document if patient retains any of the following

☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian ☐ Public Guardian/Trustee ☐ N/A

Contact information if applicable
☐Same -Contact, FINANCES ☐ Same-Contact, PERSONAL CARE ☐ Other, see below.

If OTHER list contact information
Name
Relationship to patient ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other

Address	Postal Code
Daytime Phone	Evening Phone

Financial Information *Adapted from CIHI NRS*

☐WSIB	☐Private insurance	☐OAS
☐Legal Settlement	☐Ontario Works	☐Self-employed
☐STD	☐Canadian Pension	☐No income
☐LTD	☐Auto Insurance	☐Veteran
☐ODSP	☐EI	

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 #	

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4. EPISODE INFORMATION (cont)

Patients name

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Common Law
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

Home living situation, living with: (Adapted from CIHI-NRS)

- ☐ Spouse/partner
- ☐ Family (including extended family)
- ☐ Others
- ☐ Living alone
- ☐ Not applicable
- ☐ Unknown

Caregiver support can be provided by:

- ☐ Spouse/partner
- ☐ Family (including extended family)
- ☐ Roommate or Others
- ☐ NA

Previous additional Support required:

- ☐ Attendant care
- ☐ Home support
- ☐ Privately-funded care
- ☐ None

If additional support, describe:

Can caregiver currently provide support with:

☐ **N/A**, patient does not have a caregiver

	ADL	IADL
Willing	☐	☐
Able	☐	☐
Available days	☐	☐
Available evenings	☐	☐

Comments caregiver support:

Present accommodation:

- ☐ House
- ☐ Residential group home
- ☐ Apartment Building
- ☐ Rooming house
- ☐ Unknown
- ☐ Homeless
- ☐ Other (list):

Describe accommodation barriers that must be dealt with in order for patient to return home:

- ☐ Stairs into dwelling
- ☐ Stairs to bathroom
- ☐ Stairs to bedroom
- ☐ No barriers
- ☐ Don't know
- ☐ Other (list):

Expected Discharge Destination Post Rehab:

- ☐ Home
- ☐ Home, CCAC +/- paid help
- ☐ Assisted Living (seniors apt building, retirement home)
- ☐ LTC/CCC
- ☐ Shelter/Hostel
- ☐ Don't know

Completed by:	**Date:**

* Electronic Referral cannot be made without completion of this field

5a. HEALTH ASSESSMENT

Nurse to complete

Patient's Name	**Date** **YYYY-MM-DD**
Completed by	**Nursing Unit Phone**

Weight *_____ ☐ Lbs ☐ Kilos

Height *_____ ☐ Inches ☐ Centimeters ☐ Unknown

Vision
☐ Adequate
☐ Impaired
☐ Glasses

Hearing
☐ Adequate
☐ Impaired

Comments, Vision and Hearing (list any hearing devices)

Complications after stroke ☐ **None on THIS list**

☐ Fracture after a fall
☐ Venous thromboembolism
☐ Seizures
☐ Pneumonia

Other complications (list):

Allergies * ☐ **NKDA**

List allergies:

Disorientated to:
☐ Time
☐ Person
☐ Place
Comments:

Behaviour *
At least one box to be ticked

☐ Cooperative
☐ Resistive
☐ Aggressive
☐ Suicidal ideation
☐ Repetitive speech
☐ Screams
☐ Agitated (night)
☐ Suspicious
☐ Abusive (physically)
☐ Anxious
☐ Sexually disinhibited
☐ Self mutilation
☐ Demanding
☐ Disruptive
☐ Depressed
☐ Repetitive movement
☐ Agitated (day)
☐ Agitated (sun downing)
☐ Abusive (verbally)
☐ Abusive (generally)
☐ Paranoid

Overall impact of cognition and behaviour on ADL

☐ None
☐ Mild
☐ Moderate
☐ Severe

Changes in cognition, behaviour in past week and implications on future rehab:

5b. SAFETY and SPECIAL NEEDS

Nurse to complete

Patient's Name	**Date** YYYY-MM-DD
Completed by	**Nursing Unit Phone**

Safety

Support required ☐ N/A ☐ Requires bed rails ☐ Requires gerichair ☐ Requires Hoyer lift	**Restraints used *** ☐ **N/A** ☐ Physical ☐ Chemical **Reason:** **Frequency:** **Wandering risk** ☐ **N/A** ☐ Indoor ☐ Outdoor	**Falls post stroke** ☐ **Yes** ☐ **No** **Frequency:** times per month **Reason for fall:** ☐ Balance ☐ Vision ☐ Strength ☐ Fatigue ☐ Decreased insight, judgment ☐ Other (list):

Special Needs *	**Provide details about the special needs you have checked:**
☐ **No special needs on list OR choose ALL that apply** ☐ **Tracheotomy** ☐ **Suction** ☐ **Oxygen** ☐ **IV Therapy** ☐ **Isolation** ☐ **Peritoneal Dialysis** ☐ **Hemodialysis** ☐ **Enteral Feeding†** ☐ **MRSA** ☐ **VRE** ☐ **C Difficile**	**Treatment details** **Precautions** **Procedures** **Transportation issues (e.g. dialysis)**
†Specify name of feed required	***Note: if patient has a tracheotomy or requires enteral feeding RN must complete additional form to describe management of tracheotomy or tube feeds. Forms are available from reference section of e stroke website and should be faxed with electronic referral.***

Skin condition

Ulcers present * ☐ **Yes**(complete description) ☐ **No** **If yes Braden staging grade:**	**Description**	
	Size	**Location**
	Improving? ☐ **Yes** ☐ **No**	
Other skin condition (list)		
Bladder management ☐ Indwelling catheter ☐ Condom catheter ☐ Using incontinent product ☐ Toileting required ☐ Occasional incontinence ☐ Total incontinence	**Treatment details/procedures** **Precautions**	
Bowel management ☐ Toileting required ☐ Occasional incontinence ☐ Total incontinence ☐ Using incontinent product	**Treatment details/procedures** **Precautions**	
Ostomy ☐ **Yes** ☐ **No**	**Type and care/products required**	
Ability to care for ostomy:	☐ **Independent** ☐ **Total care** ☐ **Requires supervision**	
Comments nursing		

* Electronic Referral cannot be made without completion of this field

6. REHAB ASSESSMENT: ALPHAFIM® INSTRUMENT

PT/OT to complete

Patient's Name		**DOB**	**YYYY-MM-DD**
Tester Name		**Date**	**YYYY-MM-DD**

Type of Stroke: (tick one)
☐Stroke R body ☐Stroke L body ☐Stroke no paresis ☐Stroke bilateral ☐Other stroke

Complete the AlphaFIM® Instrument items indicated below based on the distance the patient can currently walk.

Patient walks less than 150ft		Patient walks 150ft or more	
Eating		Transfers: Bed Chair	
Grooming		Walk	
Bowe Management		Bowel Management	
Transfers: Toilet		Transfers: Toilet	
Expression		Expression	
Memory		Memory	

Note: leave no blanks
enter 1 if not able to test an item due to risk

AlphaFIM® Instrument Rating Levels

No HELPER

7. Complete Independence (no device, timely, safely)

6. Modified Independence (device, not timely, or not safely)

Helper

Modified Dependence (performs 50% or more of task)

5. Supervision (patient performs 100% of the effort)

4. Minimal Assistance (patient performs 75% or more of the effort)

3. Moderate Assistance (patient performs 50% - 74% of the effort)

Complete Dependence (performs less than 50% of task)

2. Maximal Assistance (patient performs 25% - 49% of the effort)

1. Total Assistance (patient performs < 25% of the effort)

Comments:

Projected Scores from AlphaFIM® Instrument software at www.udsmr.org (select software portal, AlphaFIM® software).

FIM® 13 Raw Motor
FIM® 5 Raw Cognition
FIM® 13 Rasch Motor
FIM® 5 Rasch Cognition
FIM® Motor Range
FIM® Cognition Range
FIM® Walking Range
Help Needed

6. ABILITIES AND TOLERANCE: ORPINGTON PROGNOSTIC SCALE

PT/OT to complete

Patient's Name	**Date** YYYY-MM-DD
Tester's Name	**Phone** YYYY-MM-DD

Orpington Prognostic Scale: **Grade the patient by CIRCLING the appropriate scores below.**

Motor deficit in arm Lying supine, patient flexes shoulder to 90 degrees and is given resistance	
MRC grade 5 (normal power)	0
MRC grade 4 (diminished power)	0.4
MRC grade 3 (movement against gravity)	0.8
MRC grade 1-2 (movement with gravity eliminated or trace)	1.2
MRC grade 0 (no movement)	1.6
Proprioception (*eyes closed) *Locates affected thumb	
Accurately	0
Slight difficulty	0.4
Finds thumb via arm	0.8
Unable to find thumb	1.2
Balance	
Walks 10 feet without help	0
Maintains standing position	0.4
Maintains sitting position	0.8
No sitting balance	1.2
Cognition (Hodgkins Mental test): Can the patient recall…….	
1. Age of the patient	1
2. Time (to the nearest hour)	1
(Prompt by you) I am going to give you an address, please remember it and I will ask you later: 42 West St	
3. Name of hospital	1
4. Year	1
5. Date of birth of patient	1
6. Month	1
7. Years of Second World War (1939-1945) (approximate range okay)	1
8. Name of President of the United States	1
9. Count backwards from 20	1
10. What is the address I asked you to remember?	1

Total Orpington Prognostic Score

1.6
+
Motor score
+
Proprioception
+
Balance score
+
Cognition Score

= _____

Scoring Cognition (Score out of 10)
Mental score 10 = **0.0**
Mental score 8-9 = **0.4**
Mental score 5-7 = **0.8**
Mental score 0-4 = **1.2**

Interpretation of Stroke Severity Score

< 3.2 score = **3 minor stroke**
3.2-5.2 score = **1 moderate stroke**
> 5.2 score = **-1 major stroke**

6. ABILITIES AND TOLERANCE: ORPINGTON MODIFIERS

PT/OT to complete

Patient's name:

Stroke Modifiers	**-1** ☐	Coma at onset of stroke
	+1 ☐	Pure motor deficit
	-1 ☐	Visuospatial deficit (*draw a clock face with the time of 10 minutes after 11 am, OR if the patient cannot draw, have patient observe a clock and tell the time, or complete line bisection test)
	+1 ☐	Lacunar infarct
	-2 ☐	Bihemispheric deficit
	-1 ☐	Dysphagia
	-2 ☐	Parietal Symptoms
	-1 ☐	Incontinence persists 2 weeks or longer post stroke
Patient Modifiers	**+2** ☐	Age <55 years
	-3 ☐	*Severe cardiovascular disease* CCS Class III-IV and/or NYHA Class III-IV Angina
	-3 ☐	*Severe respiratory disease* Dyspnea Class III-IV
	-1 ☐	Coexistent symptomatic PVD
	-1 ☐	Poor Premorbid functioning
Time Modifiers	**+2** ☐	Time elapse since stroke < 2 weeks
	0 ☐	Time elapsed since stroke = 2-4 weeks
	-1 ☐	Time elapsed since stroke = 4-8 weeks
	-2 ☐	Time elapsed since stroke > 8 weeks

Modified Orpington Score (Sum of modifiers PLUS stroke severity score from previous page) .....

If final score is =≥ 0 Client is a candidate for active IP rehab programs or home rehab.
If final score is < 0 Client is a candidate for low tolerance rehabilitation programs

Or ☐ Unable to complete Orpington due to Aphasia
☐ Unable to complete Orpington due to other (list) .....

6. ABILITIES AND TOLERANCE: FUNCTION

PT/OT to complete

Patient's Name:	**Date:** **YYYY-MM-DD**
Completed by:	**Phone Number:**

Comment on changes in patient's PROGRESS (functional gains) in the past week and implications for future rehab:

Ability to participate:

Physical Activity tolerance *
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ > 1 hour

Sitting tolerance *
- ☐ **Supported**
- ☐ **Unsupported**
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >1 hour

Mental Activity Tolerance *
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >1 hour

Frequency of therapy treatment tolerated: ☐ Daily ☐ 2-3 x per week ☐ Weekly

Comment on changes in PARTICIPATION in last week and implications for future rehab:

Motivation to participate in rehabilitation (tick ALL that apply)
- ☐ Demonstrates motivation to participate in rehab (regular attendance and involvement, cooperation)
- ☐ Usually motivated to participate, occasional frustration apparent
- ☐ Motivated to participate but attendance, involvement or cooperation irregular

Is the patient experiencing shoulder pain? ☐ **Yes** ☐ **No**

Comment:

Can patient take direction, retain and execute verbal OR written OR visual instructions? ☐ **Yes** ☐ **No**

Anticipated Progress: √ the column matching anticipated independence by end of next rehab setting	**Independent with or without aids**	**Minimal assistance**	**Moderate to maximal assistance**
Locomotion			
Transfers			
ADL			
Other (list)			

Additional services:
- ☐ Pain management
- ☐ Self care & mobility assessment prescription

6. ABILITIES AND TOLERANCE - SPEECH

SLP to complete

Patient's Name	**Date** YYYY-MM-DD
Tester:	**Tester Phone**

Communication Disorder	**Speech**	**Communicates**
☐ None ☐ New ☐ Old ☐ Both new and old	☐ Adequate ☐ Receptive aphasia ☐ Expressive aphasia ☐ Dysarthria ☐ Apraxia	☐ Adequately ☐ With Difficulty ☐ Unable

Changes in COMMUNICATION status in past week and implications for future rehab:

Swallowing Disorder *	**Phase swallowing affected**	**Has videofluoroscopy been performed on this admission?**
☐ None ☐ New ☐ Old ☐ Both new and old	☐ Pharyngeal ☐ Oral ☐ Both	☐ Yes ☐ No **Repeat/videoflouroscopy recommended?** ☐ Yes ☐ No

Changes in SWALLOWING status in last week and implications for future rehab:

Diet *	**Adjusted diet: solids**	**Adjusted diet: liquids**
☐ Regular ☐ NPO ☐ PEG ☐ NG	☐ Minced diet ☐ Pureed diet ☐ Dental soft diet ☐ Snacks only ☐ Other (list below):	☐ Thin liquids ☐ Nectar thick liquids ☐ Honey thick liquids ☐ Pudding ☐ Sips of water only ☐ G-tube feeds ☐ Other (list below):

Changes in DIET in past week and implications for future rehab:

Anticipated Progress: √ the column matching anticipated level of independence by end of next rehab setting	**Independent with or without aids**	**Minimal assistance**	**Moderate to maximal assistance**
Communication			
Feeding			

Impact of communication disorder(s) on behaviour

☐ None
☐ Mild
☐ Moderate
☐ Severe

Speech, language and diet comments:

* Electronic Referral cannot be made without completion of this field

6. COGNITION AND BEHAVIOUR ASSESSMENT

Patient's Name	**Date** YYYY-MM-DD
Tester	**Phone**

Perceptual status
- ☐ Normal
- ☐ Mild Inattention
- ☐ Moderate Inattention
- ☐ Severe Inattention
- ☐ Body neglect
- ☐ Reduced depth perception
- ☐ Affected spatial awareness/skills
- ☐ Apraxia

Attention	**Memory ***	**Judgment ***	**Executive Functioning ***
☐ No deficit	☐ No deficit	☐ No deficit	☐ No deficit
☐ Mild	☐ Mild	☐ Mild	☐ Mild
☐ Moderate	☐ Moderate	☐ Moderate	☐ Moderate
☐ Severe	☐ Severe	☐ Severe	☐ Severe
☐ Unable to test	☐ Unable to test	☐ Unable to test	☐ Unable to test

Comments on COGNITION

In your opinion, rate the patient's progress in the past week
- ☐ Marked progress in the past week
- ☐ Moderate progress in the past week
- ☐ Minimal progress in the past week
- ☐ Patient has plateaued in progress in the past week
- ☐ Patient is too acute to measure progress in the past week
- ☐ Other (comment)

Comment, RATE OF PROGRESS

* Electronic Referral cannot be made without completion of this field

7. STROKE REFERRAL

Referring facility information

Primary contact for information

Your organization and/or program name

Bed offer contact name and number/pager *

Your fax number

Date referral completed **YYYY-MM-DD**

Anticipated date ready for rehab[1] or ready for transfer to rehab **YYYY-MM-DD**

Comments, ready for rehab status

Choose whether initial referral or update
☐ Initial referral
☐ Update (responding to intake need for more information)

Rehab setting type

☐Inpatient rehab HTSD or HTLD
☐Low Tolerance, long duration or LTLD

Planned referral destination/s

1. **2.**

3. **4.**

5. **6.**

Client preferred choice for referral

Preferred accommodation *
☐Ward ☐ Semi private
☐Private ☐ Other

If early referral (e.g., patient to be weaned off of NG tube, IV out, dates) specify if special needs expected to resolve before discharge

Additional referral comments

[1] Ready for rehab: Refer to Inpatient Rehab Referral Guidelines GTA Rehab Network 2005

* Electronic Referral cannot be made without completion of this field