

**GTA Rehab Network Integrated Acute Care to  
Inpatient Rehab & Complex Continuing Care (CCC) Referral Form**

This referral form is in compliance with the Provincial Referral Standards and includes supplemental information for referral to Rehab/CCC programs in the GTA.

<b>Insert Health Service Provider Logo</b>	<b>Patient Identification</b>	
<b>Referral Destination</b>		
<input type="checkbox"/> <i>Referral to Rehab: (Please check one)</i> <input type="checkbox"/> HTSD / Regular stream <input type="checkbox"/> LTLD/slowstream <input type="checkbox"/> Either (Receiving facility to determine) <input type="checkbox"/> <i>Referral to Complex Continuing Care (CCC) (For LTLD / slowstream rehab, select within Rehab Category above)</i>		
If Faxed Include Number of Pages (Including Cover): _____ Pages		
<b>Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY</b>		
<b>Patient Details and Demographics</b>		
Health Card #: _____	Version Code: _____	Province Issuing Health Card: _____
No Health Card #: <input type="checkbox"/>	No Version Code: <input type="checkbox"/>	
Surname: _____	Given Name(s): _____	
No Known Address: <input type="checkbox"/>		
Home Address: _____	City: _____	Province: _____
Postal Code: _____	Country: _____	Telephone: _____
		Alternate Telephone: _____ No Alternate Telephone: <input type="checkbox"/>
Current Place of Residence (Complete If Different From Home Address): _____		
Date of Birth: DD/MM/YYYY	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	Marital Status: _____
Patient Speaks/Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No    Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other _____		
Primary Alternate Contact Person: Relationship to Patient (Please Check All Applicable Boxes): <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____		
Telephone: _____	Alternate Telephone: _____	No Alternate Telephone: <input type="checkbox"/>

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Secondary Alternate Contact Person: _____ None Provided: <input type="checkbox"/> Relationship to Patient: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ (Please Check All Applicable Boxes) Telephone: _____ Alternate Telephone: _____ No Alternate Telephone: <input type="checkbox"/>	
<b>Responsibility for Payment:</b> Insurance: _____ N/A: <input type="checkbox"/> <input type="checkbox"/> OHIP <input type="checkbox"/> Federal Government <input type="checkbox"/> IFH (Interim Federal Health Grant) <input type="checkbox"/> Inter-provincial Insurance Plan <input type="checkbox"/> Insured/Self Pay <input type="checkbox"/> Other Payment Sources <input type="checkbox"/> WSIB <input type="checkbox"/> Uninsured/Self Pay <input type="checkbox"/> Unknown	
<b>Preferred accommodation:</b> <input type="checkbox"/> Ward <input type="checkbox"/> Semi private <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	
<b>For CCC Only</b> - Co-Payment Discussed With: <input type="checkbox"/> Patient <input type="checkbox"/> Other _____	
<b>Rehab/CCC Population Requested:</b> <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> Chronic Ventilation <input type="checkbox"/> General/Medical <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neuro <input type="checkbox"/> Oncology <input type="checkbox"/> Respiratory Rehab <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Stroke <input type="checkbox"/> Trauma <input type="checkbox"/> Transplant <input type="checkbox"/> Other _____	
<b>Current Location Name:</b> _____ <b>Current Location Address:</b> _____ <b>City:</b> _____ <b>Province:</b> _____ <b>Postal Code:</b> _____	
<b>Current Location Contact Number:</b> _____ <b>Bed Offer Contact Name:</b> _____ <b>Bed Offer Contact Number:</b> _____	
<b>Medical Information</b>	
<b>Primary Health Care Provider (e.g. MD or NP)</b> _____ <b>Surname:</b> _____ <b>Given Name(s):</b> _____ <input type="checkbox"/> None	
<b>Allergies:</b> <input type="checkbox"/> No Known Allergies <input type="checkbox"/> Yes --- If Yes, List Allergies: _____	
<b>Infection Control:</b> <input type="checkbox"/> None <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CDIFF <input type="checkbox"/> ESBL <input type="checkbox"/> TB <input type="checkbox"/> Other (Specify): _____	
<b>Admission Date: DD/MM/YYYY</b> <b>Date of Injury/Event: DD/MM/YYYY</b> <b>Surgery Date: DD/MM/YYYY</b>	

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<b>Insert Health Service Provider Logo</b>	<b>Patient Identification</b>
Nature/Type of Injury/Event:	
Primary Diagnosis:	
Current Medical Issues:	
Past Medical History:	
<b>Attach the following:</b> Medication: <input type="checkbox"/> MAR Lab Work: <input type="checkbox"/> If indicated, send most recent lab work (e.g. Haemoglobin, white blood cell count, lytes, creatinine)	
Height:	Weight:
Is Patient Currently Receiving Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis Frequency/Days: _____ Location: _____  <b>If Dialysis Centre is located off-site from rehab/CCC, indicate how patient will access Dialysis Centre:</b> <input type="checkbox"/> Family drives <input type="checkbox"/> Volunteer drives <input type="checkbox"/> Wheel-Trans <input type="checkbox"/> Other _____	
Is Patient Currently Receiving Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____ Duration: _____ Location: _____	
Is Patient Currently Receiving Radiation Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____ Duration: _____ Location: _____	
Concurrent Treatment Requirements Off-Site: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Prognosis: <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Palliative Palliative Performance Scale: _____ <input type="checkbox"/> Unknown	

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<b>Insert Health Service Provider Logo</b>	<b>Patient Identification</b>
Advanced Medical Directives:	
Services Consulted: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SW <input type="checkbox"/> Speech and Language Pathology <input type="checkbox"/> Nutrition <input type="checkbox"/> Other _____	
Pending Investigations: <input type="checkbox"/> Yes <input type="checkbox"/> No Details:	
Frequency of Lab Tests: _____ Unknown: <input type="checkbox"/> None: <input type="checkbox"/>	
Study Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No Details:	
<b>Respiratory Care Requirements</b>	
Does the Patient Have Respiratory Care Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	
Supplemental Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No Ventilator: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Target O2 Sat _____ % <input type="checkbox"/> Intermittent Oxygen _____ L/min <input type="checkbox"/> Constant Oxygen _____ L/min	
<input type="checkbox"/> O2 at rest _____ L/min <input type="checkbox"/> O2 at exercise _____ L/min	
Special Oxygen Equipment/Human Resources required? (e.g. rebreather, Optiflow, specialized resources of Respiratory Therapist): <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please specify): _____	
Breath Stacking: <input type="checkbox"/> Yes <input type="checkbox"/> No Insufflation/Exsufflation: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cuffed <input type="checkbox"/> Cuffless Type: _____ Size: _____	
Suctioning: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____	
C-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bi-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No Rescue Rate: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments:	
<b>IV Therapy</b>	
IV in Use? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	

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<b>Insert Health Service Provider Logo</b>	<b>Patient Identification</b>
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IV Therapy:  Yes  No                      Central Line:  Yes  No                      PICC Line :  Yes  No

Name of IV Medication: \_\_\_\_\_

**Hearing/Vision**

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

**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     Tube Type: \_\_\_\_\_     Specify Formula Type & Rate of Feeds: \_\_\_\_\_

Diet:  Regular     Kosher     Diabetic     Renal     Low Sodium     Other (specify): \_\_\_\_\_

**Falls**

Does Patient Have a History of Falls?  Yes  No -- If No, Skip to Next Section

If yes, specify:  home/community       hospital

History & Frequency:  Frequent     Rare     Intermittent

Reason for most recent fall(s):

Balance             Vision             Strength             Fatigue             Decreased insight/judgment             Unknown

Other (list): \_\_\_\_\_

**Skin Condition**

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

1. Location: \_\_\_\_\_                      Stage: \_\_\_\_\_

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This referral form is in compliance with the Provincial Referral Standards and includes supplemental information for referral to Rehab/CCC programs in the GTA.

<b>Insert Health Service Provider Logo</b>	<b>Patient Identification</b>
Dressing Type: _____ Frequency: _____ (e.g. Negative Pressure Wound Therapy or VAC)	
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
<b>2. Location:</b> _____ <b>Stage:</b> _____ Dressing Type: _____ Frequency: _____ (e.g. Negative Pressure Wound Therapy or VAC)	
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
<b>3. Location:</b> _____ <b>Stage:</b> _____ Dressing Type: _____ Frequency: _____ (e.g. Negative Pressure Wound Therapy or VAC)	
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
<b>* If additional wounds exist, add supplementary information on a separate sheet of paper.</b>	
<b>Continence</b>	
Is Patient Continent? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If Yes, Skip to Next Section	
Bladder Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent
Bowel Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent
Ostomy: <input type="checkbox"/> N/A <input type="checkbox"/> Yes <b>Type/brand and care/products required</b> _____	
Ability to care for ostomy: <input type="checkbox"/> Independent <input type="checkbox"/> Total care <input type="checkbox"/> Requires supervision	
<b>Pain Care Requirements</b>	
Does the Patient Have a Pain Management Strategy? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	
Controlled With Oral Analgesics: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medication Pump: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Methadone: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Epidural: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a Pain Plan of Care Been Started: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Communication</b>	
Does the Patient Have a Communication Impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	

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<i>Insert Health Service Provider Logo</i>	<b>Patient Identification</b>
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Communication Impairment Description:

**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: \_\_\_\_\_

Cognitive Status (Complete Table Below)	Not Tested	Intact	Impaired
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Able to follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Memory (short term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Memory (long term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Frustration Tolerance (ABI only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
<input type="checkbox"/> MMSE Score: _____ or <input type="checkbox"/> MoCA Score: _____	<input type="checkbox"/>	If did not/unable to complete, please explain:	

Rancho Los Amigos Cognitive Scale at present: (ABI only): \_\_\_\_\_

Delirium:  Yes  No -- If Yes, Cause/Details: \_\_\_\_\_

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<b>Insert Health Service Provider Logo</b>	<b>Patient Identification</b>
History of Diagnosed Dementia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Behaviour</b>	
Are There Behavioural Issues? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	
Does the Patient Have a Behaviour Management Strategy: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Behaviour: <input type="checkbox"/> Need for Constant Observation <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Agitation <input type="checkbox"/> Wandering <input type="checkbox"/> Sundowning <input type="checkbox"/> Exit-Seeking <input type="checkbox"/> Resisting Care <input type="checkbox"/> Other <input type="checkbox"/> Restraints -- If Yes, Type/Frequency Details : _____	
Level of Security: <input type="checkbox"/> Non-Secure Unit <input type="checkbox"/> Secure Unit <input type="checkbox"/> Wander Guard <input type="checkbox"/> One-to-one	
<b>Social History</b>	
Discharge Destination: <input type="checkbox"/> Multi-Storey <input type="checkbox"/> Bungalow <input type="checkbox"/> Apartment <input type="checkbox"/> LTC <input type="checkbox"/> Retirement Home (Name): _____	
Accommodation Barriers: <span style="float: right;"><input type="checkbox"/> Unknown</span>	
Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Alcohol and/or Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Previous Community Supports: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Discharge Planning Post Hospitalization Addressed: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Discharge Plan Discussed With Patient/SDM: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Current Functional Status</b>	
Patient Goals (Please Indicate Specific, Measurable Goals):  _____	
Participation Level: (Specify): On average, patient is able to participate in _____ therapy sessions / day, _____ times / week for _____ minutes / session	
Sitting Tolerance: <input type="checkbox"/> More Than 2 Hours Daily <input type="checkbox"/> 1-2 Hours Daily <input type="checkbox"/> Less Than 1 Hour Daily <input type="checkbox"/> Has not Been Up	
Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Mechanical Lift	



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Ambulation:     Independent     Supervision     Assist x1     Assist x2     Unable

Number of Metres: \_\_\_\_\_

Stairs:         Independent     Supervision     Assist x1     Assist x2     Stair Lift/Glider

**Weight Bearing Status:**

**Left:**    U/E     L/E  
 Full    As Tolerated    Partial \_\_\_\_\_%    Toe Touch    Non      Date expected to be weight-bearing \_\_\_\_\_  
DD/MM/YYYY

**Right:**  U/E     L/E  
 Full    As Tolerated    Partial \_\_\_\_\_%    Toe Touch    Non      Date expected to be weight-bearing \_\_\_\_\_  
DD/MM/YYYY

**Limbs:**

**Left:**    U/E impairment                       L/E impairment     Aid(s) Required: \_\_\_\_\_

**Right:**  U/E impairment                       L/E impairment     Aid(s) Required: \_\_\_\_\_

Bed Mobility:     Independent     Supervision     Assist x1     Assist x2

### Activities of Daily Living

**Describe 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)						

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<b>Insert Health Service Provider Logo</b>				<b>Patient Identification</b>		
Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Dressing: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						
<b>Special Equipment Needs</b>						
Special Equipment Required? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section						
<input type="checkbox"/> HALO <input type="checkbox"/> Orthosis (including splints, slings) <input type="checkbox"/> Bariatric - If Yes, Please Describe Equipment Needs: _____ <input type="checkbox"/> Other: _____						
Pleuracentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No      Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, Type Details: _____						
Paracentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No      Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, Type Details: _____						
Need for a Specialized Mattress: <input type="checkbox"/> Yes <input type="checkbox"/> No      Negative Pressure Wound Therapy (NPWT): <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b><u>Rehab Specific</u> AlphaFIM® Instrument</b>						
Is AlphaFIM® Data Available: <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section						
Has the Patient Been Observed Walking 150 Feet or More: <input type="checkbox"/> Yes <input type="checkbox"/> No						
If Yes – Raw Ratings (rate levels 1-7)	Transfer: Bed, Chair _____	Expression _____		Transfers: Toilet _____		
	Bowel Management _____	Locomotion: Walk _____		Memory _____		
If No – Raw Ratings (rate levels 1-7)	Eating _____	Expression _____		Transfers :Toilet _____		
	Bowel Management _____	Grooming _____		Memory _____		
Projected:	FIM® projected Raw Motor (13):		FIM® projected Cognitive (5):			
	Help Needed:					

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**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:**

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