

# 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  MinimalInterpreter 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.

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Patient's Name																					
Date of Stroke Onset (or Date Last Seen Normal) *			YYYY-MM-DD																		
First Stroke? * <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Previous Stroke		YYYY-MM-DD																		
<b>Deficits Previous Stroke</b>																					
<b>Type of Stroke*</b> (current stroke)	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Transforming to Hemorrhagic																				
<b>Stroke Location</b> (most recent CT/MRI)	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;"><input type="checkbox"/> Left</td> <td><input type="checkbox"/> Frontal</td> </tr> <tr> <td><input type="checkbox"/> Right</td> <td><input type="checkbox"/> Parietal</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Occipital</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Temporal</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Internal Capsule</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Basal ganglia</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Thalamus</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Cerebellum</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Brainstem</td> </tr> </table>			<input type="checkbox"/> Left	<input type="checkbox"/> Frontal	<input type="checkbox"/> Right	<input type="checkbox"/> Parietal		<input type="checkbox"/> Occipital		<input type="checkbox"/> Temporal		<input type="checkbox"/> Internal Capsule		<input type="checkbox"/> Basal ganglia		<input type="checkbox"/> Thalamus		<input type="checkbox"/> Cerebellum		<input type="checkbox"/> Brainstem
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	<input type="checkbox"/> Basal ganglia																				
	<input type="checkbox"/> Thalamus																				
	<input type="checkbox"/> Cerebellum																				
	<input type="checkbox"/> Brainstem																				
<b>Mechanism of Stroke</b>	<input type="checkbox"/> Carotid Stenosis Required Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cardioembolic <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Dilated Cardiomyopathy or other structural/wall movement abnormality <input type="checkbox"/> Valvular problem <input type="checkbox"/> Dissection <input type="checkbox"/> Carotid <input type="checkbox"/> Vertebral <input type="checkbox"/> Small Vessel Thrombosis <input type="checkbox"/> Auto Immune <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Provide details) .....																				
<b>Deficits Current Stroke</b>																					
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><input type="checkbox"/> L Hemiparesis</td> <td style="width: 25%;"><input type="checkbox"/> R Hemiparesis</td> <td style="width: 25%;"><input type="checkbox"/> No Paresis</td> <td style="width: 25%;"><input type="checkbox"/> Aphasia</td> </tr> <tr> <td><input type="checkbox"/> Dysphagia</td> <td><input type="checkbox"/> Apraxia</td> <td><input type="checkbox"/> Sensory Neglect</td> <td><input type="checkbox"/> Ataxia</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Other (provide details): .....</td> </tr> </table>				<input type="checkbox"/> L Hemiparesis	<input type="checkbox"/> R Hemiparesis	<input type="checkbox"/> No Paresis	<input type="checkbox"/> Aphasia	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Apraxia	<input type="checkbox"/> Sensory Neglect	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Other (provide details): .....									
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<input type="checkbox"/> Other (provide details): .....																					
<b>Old/Chronic CT or MRI Findings</b>	<input type="checkbox"/> None <input type="checkbox"/> Evidence of previous infarcts <input type="checkbox"/> Sub cortical white matter changes - Mild <input type="checkbox"/> Sub cortical white matter changes - Moderate <input type="checkbox"/> Sub cortical white matter changes - Severe																				
<b>Stroke Workup</b>																					
<b>Echocardiogram</b>	<b>Holter Monitor</b>	<b>Carotid Imaging</b>	<b>Secondary Prevention Clinic</b>																		
<input type="checkbox"/> Done	<input type="checkbox"/> Done	<input type="checkbox"/> Done	<input type="checkbox"/> Booked ____/____/____ yyyy/mm/dd																		
<input type="checkbox"/> Not indicated	<input type="checkbox"/> Not indicated	<input type="checkbox"/> Not indicated	<input type="checkbox"/> Referred																		
<input type="checkbox"/> Booked ____/____/____ yy/mm/dd	<input type="checkbox"/> Booked ____/____/____ yy/mm/dd	<input type="checkbox"/> Booked ____/____/____ yy/mm/dd	<input type="checkbox"/> Not Required																		

Toronto Stroke Networks Last modified March 2, 2011  
 \* Electronic Referral cannot be made without completion of this field

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

<b>Patients Name</b>																					
<b>Specific conditions impacting on rehab potential</b> <input type="checkbox"/> None on this list <input type="checkbox"/> Angina <input type="checkbox"/> Coronary Artery bypass Surgery or Stenting procedure <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Amputation <input type="checkbox"/> Asthma <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Cerebral Vasculitis <input type="checkbox"/> Other (list): .....																					
<b>Charleston Comorbidities Index</b> <input type="checkbox"/> No comorbidities on THIS list  <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input type="checkbox"/> (1) Myocardial Infarct</td> <td style="width: 33%; border: none;"><input type="checkbox"/> (1) Diabetes</td> <td rowspan="10" style="width: 33%; border: 1px solid black; padding: 5px; text-align: center;">                     The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores &gt; 3 may not tolerate rehabilitation                 </td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Congestive Heart failure</td> <td style="border: none;"><input type="checkbox"/> (2) Hemiplegia (Pre-existing)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Peripheral Vascular disease</td> <td style="border: none;"><input type="checkbox"/> (2) Moderate or severe renal disease</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Cerebrovascular disease</td> <td style="border: none;"><input type="checkbox"/> (2) Diabetes with end organ damage</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Dementia</td> <td style="border: none;"><input type="checkbox"/> (2) Any tumor</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Chronic pulmonary disease</td> <td style="border: none;"><input type="checkbox"/> (2) Leukemia</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Connective tissue disease</td> <td style="border: none;"><input type="checkbox"/> (2) Lymphoma</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Ulcer</td> <td style="border: none;"><input type="checkbox"/> (3) Moderate or severe liver disease</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> (1) Mild liver disease</td> <td style="border: none;"><input type="checkbox"/> (3) AIDS</td> </tr> </table> <input type="checkbox"/> Other Comorbid Conditions of Significance (list): .....			<input type="checkbox"/> (1) Myocardial Infarct	<input type="checkbox"/> (1) Diabetes	The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores > 3 may not tolerate rehabilitation	<input type="checkbox"/> (1) Congestive Heart failure	<input type="checkbox"/> (2) Hemiplegia (Pre-existing)	<input type="checkbox"/> (1) Peripheral Vascular disease	<input type="checkbox"/> (2) Moderate or severe renal disease	<input type="checkbox"/> (1) Cerebrovascular disease	<input type="checkbox"/> (2) Diabetes with end organ damage	<input type="checkbox"/> (1) Dementia	<input type="checkbox"/> (2) Any tumor	<input type="checkbox"/> (1) Chronic pulmonary disease	<input type="checkbox"/> (2) Leukemia	<input type="checkbox"/> (1) Connective tissue disease	<input type="checkbox"/> (2) Lymphoma	<input type="checkbox"/> (1) Ulcer	<input type="checkbox"/> (3) Moderate or severe liver disease	<input type="checkbox"/> (1) Mild liver disease	<input type="checkbox"/> (3) AIDS
<input type="checkbox"/> (1) Myocardial Infarct	<input type="checkbox"/> (1) Diabetes	The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores > 3 may not tolerate rehabilitation																			
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<input type="checkbox"/> (1) Mild liver disease	<input type="checkbox"/> (3) AIDS																				
<b>Previous psychiatric history *</b> No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes describe history and status _____ _____																					
<b>Current psychiatric diagnosis *</b> No <input type="checkbox"/> Yes <input type="checkbox"/> if Yes specify diagnosis and status _____ _____																					
<b>Surgical History</b> <input type="checkbox"/> No surgeries List surgeries during this hospitalization with date: _____ Complications resulting from surgery: _____																					
<b>Referring Physician's Name</b>	<b>Date</b>	YYYY-MM-DD																			
<b>Attending Physician's Name</b>																					

## 4. EPISODE INFORMATION

Patient's Name		MRN/Chart Number
Patient's admission date to this facility		YYYY-MM-DD
<b>FINANCES</b>		
Who manages the patient's FINANCES now? <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Don't Know		
If OTHERS, list contact information contact person, FINANCES		
Name		
Relationship to patient <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
<b>PERSONAL CARE</b>		
Who manages the patient's PERSONAL CARE decisions now? <input type="checkbox"/> Self <input type="checkbox"/> Others		
If others, list contact information <input type="checkbox"/> Same as contact person, FINANCES OR		
Contact Person, PERSONAL CARE decisions		
Name		
Relationship to patient <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
<b>SUBSTITUTE DECISION MAKER</b>		
Document if patient retains any of the following		
<input type="checkbox"/> A substitute decision maker <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Public Guardian/Trustee <input type="checkbox"/> N/A		
Contact information if applicable		
<input type="checkbox"/> Same -Contact, FINANCES <input type="checkbox"/> Same-Contact, PERSONAL CARE <input type="checkbox"/> Other, see below.		
If OTHER list contact information		
Name		
Relationship to patient <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
<b>Financial Information</b> Adapted from CIHI NRS		
<input type="checkbox"/> WSIB <input type="checkbox"/> Private insurance <input type="checkbox"/> OAS <input type="checkbox"/> Legal Settlement <input type="checkbox"/> Ontario Works <input type="checkbox"/> Self-employed <input type="checkbox"/> STD <input type="checkbox"/> Canadian Pension <input type="checkbox"/> No income <input type="checkbox"/> LTD <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Veteran <input type="checkbox"/> ODSP <input type="checkbox"/> EI		
<b>Responsibility for Payment</b> Source: CIHI NRS		
<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		
If insurance payment		
Name of insurer	Claim #	Certificate #
Group number	Policy #	

### 4. EPISODE INFORMATION (cont)

<b>Patients name</b>		
<b>Marital Status:</b>		
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	
<input type="checkbox"/> Common Law	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Separated		
<b>Home living situation, living with:</b> (Adapted from CIHI-NRS)		
<input type="checkbox"/> Spouse/partner	<input type="checkbox"/> Living alone	
<input type="checkbox"/> Family (including extended family)	<input type="checkbox"/> Not applicable	
<input type="checkbox"/> Others	<input type="checkbox"/> Unknown	
<b>Caregiver support can be provided by:</b>		
<input type="checkbox"/> Spouse/partner	<input type="checkbox"/> Roommate or Others	
<input type="checkbox"/> Family (including extended family)	<input type="checkbox"/> NA	
<b>Previous additional Support required:</b>		
<input type="checkbox"/> Attendant care		
<input type="checkbox"/> Home support		
<input type="checkbox"/> Privately-funded care		
<input type="checkbox"/> None		
<b>If additional support, describe:</b>		
<b>Can caregiver currently provide support with:</b>		
<input type="checkbox"/> N/A, patient does not have a caregiver	<b>ADL</b>	<b>IADL</b>
Willing	<input type="checkbox"/>	<input type="checkbox"/>
Able	<input type="checkbox"/>	<input type="checkbox"/>
Available days	<input type="checkbox"/>	<input type="checkbox"/>
Available evenings	<input type="checkbox"/>	<input type="checkbox"/>
<b>Comments caregiver support:</b>		
<b>Present accommodation:</b>		
<input type="checkbox"/> House		
<input type="checkbox"/> Residential group home		
<input type="checkbox"/> Apartment Building		
<input type="checkbox"/> Rooming house		
<input type="checkbox"/> Unknown		
<input type="checkbox"/> Homeless		
<input type="checkbox"/> Other (list):		
<b>Describe accommodation barriers that must be dealt with in order for patient to return home:</b>		
<input type="checkbox"/> Stairs into dwelling		
<input type="checkbox"/> Stairs to bathroom		
<input type="checkbox"/> Stairs to bedroom		
<input type="checkbox"/> No barriers		
<input type="checkbox"/> Don't know		
<input type="checkbox"/> Other (list):		
<b>Expected Discharge Destination Post Rehab:</b>		
<input type="checkbox"/> Home		
<input type="checkbox"/> Home, CCAC +/- paid help		
<input type="checkbox"/> Assisted Living (seniors apt building, retirement home)		
<input type="checkbox"/> LTC/CCC		
<input type="checkbox"/> Shelter/Hostel		
<input type="checkbox"/> Don't know		
<b>Completed by:</b>	<b>Date:</b>	

## 5a. HEALTH ASSESSMENT

Nurse to complete

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<b>Patient's Name</b>		<b>Date</b> YYY-MM-DD
<b>Completed by</b>		<b>Nursing Unit Phone</b>
<b>Weight *</b> _____ <input type="checkbox"/> Lbs <input type="checkbox"/> Kilos		<b>Height *</b> _____ <input type="checkbox"/> Inches <input type="checkbox"/> Centimeters <input type="checkbox"/> Unknown
<b>Vision</b> <input type="checkbox"/> Adequate <input type="checkbox"/> Impaired <input type="checkbox"/> Glasses	<b>Hearing</b> <input type="checkbox"/> Adequate <input type="checkbox"/> Impaired	<b>Comments, Vision and Hearing</b> (list any hearing devices)
<b>Complications after stroke</b> <input type="checkbox"/> None on THIS list <input type="checkbox"/> Fracture after a fall <input type="checkbox"/> Venous thromboembolism <input type="checkbox"/> Seizures <input type="checkbox"/> Pneumonia <b>Other complications (list):</b>		
<b>Allergies *</b> <input type="checkbox"/> NKDA <b>List allergies:</b>		
<b>Disorientated to:</b> <input type="checkbox"/> Time <input type="checkbox"/> Person <input type="checkbox"/> Place <b>Comments:</b>		
<b>Behaviour *</b> At least one box to be ticked	<input type="checkbox"/> Cooperative <input type="checkbox"/> Resistive <input type="checkbox"/> Aggressive <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Repetitive speech <input type="checkbox"/> Screams <input type="checkbox"/> Agitated (night) <input type="checkbox"/> Suspicious <input type="checkbox"/> Abusive (physically) <input type="checkbox"/> Anxious <input type="checkbox"/> Sexually disinhibited	<input type="checkbox"/> Self mutilation <input type="checkbox"/> Demanding <input type="checkbox"/> Disruptive <input type="checkbox"/> Depressed <input type="checkbox"/> Repetitive movement <input type="checkbox"/> Agitated (day) <input type="checkbox"/> Agitated (sun downing) <input type="checkbox"/> Abusive (verbally) <input type="checkbox"/> Abusive (generally) <input type="checkbox"/> Paranoid
<b>Overall impact of cognition and behaviour on ADL</b>	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
<b>Changes in cognition, behaviour in past week and implications on future rehab:</b>		

### 5b. SAFETY and SPECIAL NEEDS

Nurse to complete

<b>Patient's Name</b>	<b>Date</b> <span style="float:right">YYYY-MM-DD</span>
<b>Completed by</b>	<b>Nursing Unit Phone</b>

**Safety**

<b>Support required</b> <input type="checkbox"/> N/A <input type="checkbox"/> Requires bed rails <input type="checkbox"/> Requires gerichair <input type="checkbox"/> Requires Hoyer lift	<b>Restraints used *</b> <input type="checkbox"/> N/A <input type="checkbox"/> Physical <input type="checkbox"/> Chemical <b>Reason:</b>  <b>Frequency:</b>  <b>Wandering risk</b> <input type="checkbox"/> N/A <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor	<b>Falls post stroke</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Frequency:</b> _____ times per month <b>Reason for fall:</b> <input type="checkbox"/> Balance <input type="checkbox"/> Vision <input type="checkbox"/> Strength <input type="checkbox"/> Fatigue <input type="checkbox"/> Decreased insight, judgment <input type="checkbox"/> Other (list): _____
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**Special Needs \*** Provide details about the special needs you have checked:

<input type="checkbox"/> No special needs on list OR choose ALL that apply <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Suction <input type="checkbox"/> Oxygen <input type="checkbox"/> IV Therapy <input type="checkbox"/> Isolation <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Enteral Feeding† <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C Difficile	Treatment details  Precautions  Procedures  Transportation issues (e.g. dialysis)
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†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**

<b>Ulcers present *</b> <input type="checkbox"/> Yes (complete description) <input type="checkbox"/> No If yes Braden staging grade: _____	<b>Description</b>  <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"><b>Size</b></td> <td style="width:50%;"><b>Location</b></td> </tr> </table> Improving? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Size</b>	<b>Location</b>
<b>Size</b>	<b>Location</b>		

**Other skin condition (list)**

<b>Bladder management</b> <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Condom catheter <input type="checkbox"/> Using incontinent product <input type="checkbox"/> Toileting required <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Total incontinence	Treatment details/procedures  Precautions
<b>Bowel management</b> <input type="checkbox"/> Toileting required <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Total incontinence <input type="checkbox"/> Using incontinent product	Treatment details/procedures  Precautions
<b>Ostomy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Type and care/products required

**Ability to care for ostomy:**     Independent     Total care     Requires supervision

**Comments nursing**

**6. REHAB ASSESSMENT:  
ALPHAFIM® INSTRUMENT**  
PT/OT to complete

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<b>Patient's Name</b>	<b>DOB</b>	<b>YYYY-MM-DD</b>
<b>Tester Name</b>	<b>Date</b>	<b>YYYY-MM-DD</b>

**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		AlphaFIM® Instrument Rating Levels
Eating		Transfers: Bed Chair		<p><b>No HELPER</b></p> <p>7. Complete Independence (no device, timely, safely)</p> <p>6. Modified Independence (device, not timely, or not safely)</p> <p><b>Helper</b></p> <p><b>Modified Dependence (performs 50% or more of task)</b></p> <p>5. Supervision (patient performs 100% of the effort)</p> <p>4. Minimal Assistance (patient performs 75% or more of the effort)</p> <p>3. Moderate Assistance (patient performs 50% - 74% of the effort)</p> <p><b>Complete Dependence (performs less than 50% of task)</b></p> <p>2. Maximal Assistance (patient performs 25% - 49% of the effort)</p> <p>1. Total Assistance (patient performs &lt; 25% of the effort)</p>
Grooming		Walk		
Bowel Management		Bowel Management		
Transfers: Toilet		Transfers: Toilet		
Expression		Expression		
Memory		Memory		
<p><b>Note: leave no blanks enter 1 if not able to test an item due to risk</b></p>				

**Comments:**

**Projected Scores from AlphaFIM® Instrument software at [www.udsmr.org](http://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

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## 6. ABILITIES AND TOLERANCE: ORPINGTON PROGNOSTIC SCALE

PT/OT to complete

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<b>Patient's Name</b>	<b>Date</b>	YYYY-MM-DD
<b>Tester's Name</b>	<b>Phone</b>	YYYY-MM-DD
<b>Orpington Prognostic Scale: Grade the patient by CIRCLING the appropriate scores below.</b>		
<b>Motor deficit in arm Lying supine, patient flexes shoulder to 90 degrees and is given resistance</b>		<b>Total Orpington Prognostic Score</b>  1.6 + Motor score + Proprioception + Balance score + Cognition Score  = _____
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	
<b>Proprioception (eyes closed) Locates affected thumb</b>		
Accurately	0	
Slight difficulty	0.4	
Finds thumb via arm	0.8	
Unable to find thumb	1.2	
<b>Balance</b>		
Walks 10 feet without help	0	
Maintains standing position	0.4	
Maintains sitting position	0.8	
No sitting balance	1.2	
<b>Cognition (Hodgkins Mental test): Can the patient recall.....</b>		<b>Scoring Cognition (Score out of 10)</b> Mental score 10 = 0.0 Mental score 8-9 = 0.4 Mental score 5-7 = 0.8 Mental score 0-4 = 1.2
1. Age of the patient	1	
2. Time (to the nearest hour)	1	
<b>(Prompt by you) I am going to give you an address, please remember it and I will ask you later: 42 West St</b>		<b>Interpretation of Stroke Severity Score</b>  < 3.2 score = 3 minor stroke 3.2-5.2 score = 1 moderate stroke > 5.2 score = -1 major stroke
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	

## 6. ABILITIES AND TOLERANCE: ORPINGTON MODIFIERS

PT/OT to complete

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Patient's name:

<b>Stroke Modifiers</b>	-1 <input type="checkbox"/>	Coma at onset of stroke
	+1 <input type="checkbox"/>	Pure motor deficit
	-1 <input type="checkbox"/>	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 <input type="checkbox"/>	Lacunar infarct
	-2 <input type="checkbox"/>	Bihemispheric deficit
	-1 <input type="checkbox"/>	Dysphagia
	-2 <input type="checkbox"/>	Parietal Symptoms
	-1 <input type="checkbox"/>	Incontinence persists 2 weeks or longer post stroke
<b>Patient Modifiers</b>	+2 <input type="checkbox"/>	Age <55 years
	-3 <input type="checkbox"/>	Severe cardiovascular disease CCS Class III-IV and/or NYHA Class III-IV Angina
	-3 <input type="checkbox"/>	Severe respiratory disease Dyspnea Class III-IV
	-1 <input type="checkbox"/>	Coexistent symptomatic PVD
	-1 <input type="checkbox"/>	Poor Premorbid functioning
<b>Time Modifiers</b>	+2 <input type="checkbox"/>	Time elapse since stroke < 2 weeks
	0 <input type="checkbox"/>	Time elapsed since stroke = 2-4 weeks
	-1 <input type="checkbox"/>	Time elapsed since stroke = 4-8 weeks
	-2 <input type="checkbox"/>	Time elapsed since stroke > 8 weeks

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

**If final score is  $\geq 0$  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

<b>Patient's Name:</b>	<b>Date:</b> YYYY-MM-DD						
<b>Completed by:</b>	<b>Phone Number:</b>						
<b>Comment on changes in patient's PROGRESS (functional gains) in the past week and implications for future rehab:</b>							
<p><b>Ability to participate:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <b>Physical Activity tolerance *</b>  <input type="checkbox"/> 15-30 minutes  <input type="checkbox"/> 30-60 minutes  <input type="checkbox"/> &gt; 1 hour                 </td> <td style="width: 33%; vertical-align: top;"> <b>Sitting tolerance *</b>  <input type="checkbox"/> <b>Supported</b>  <input type="checkbox"/> <b>Unsupported</b>  <input type="checkbox"/> 15-30 minutes  <input type="checkbox"/> 30-60 minutes  <input type="checkbox"/> &gt;1 hour                 </td> <td style="width: 33%; vertical-align: top;"> <b>Mental Activity Tolerance *</b>  <input type="checkbox"/> 15-30 minutes  <input type="checkbox"/> 30-60 minutes  <input type="checkbox"/> &gt;1 hour                 </td> </tr> <tr> <td colspan="3"> <b>Frequency of therapy treatment tolerated:</b>   <input type="checkbox"/> Daily   <input type="checkbox"/> 2-3 x per week   <input type="checkbox"/> Weekly                 </td> </tr> </table>		<b>Physical Activity tolerance *</b> <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> > 1 hour	<b>Sitting tolerance *</b> <input type="checkbox"/> <b>Supported</b> <input type="checkbox"/> <b>Unsupported</b> <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> >1 hour	<b>Mental Activity Tolerance *</b> <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> >1 hour	<b>Frequency of therapy treatment tolerated:</b> <input type="checkbox"/> Daily <input type="checkbox"/> 2-3 x per week <input type="checkbox"/> Weekly		
<b>Physical Activity tolerance *</b> <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> > 1 hour	<b>Sitting tolerance *</b> <input type="checkbox"/> <b>Supported</b> <input type="checkbox"/> <b>Unsupported</b> <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> >1 hour	<b>Mental Activity Tolerance *</b> <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> >1 hour					
<b>Frequency of therapy treatment tolerated:</b> <input type="checkbox"/> Daily <input type="checkbox"/> 2-3 x per week <input type="checkbox"/> Weekly							
<b>Comment on changes in PARTICIPATION in last week and implications for future rehab:</b>							
<p><b>Motivation to participate in rehabilitation (tick ALL that apply)</b></p> <input type="checkbox"/> Demonstrates motivation to participate in rehab (regular attendance and involvement, cooperation) <input type="checkbox"/> Usually motivated to participate, occasional frustration apparent <input type="checkbox"/> Motivated to participate but attendance, involvement or cooperation irregular							
<p><b>Is the patient experiencing shoulder pain?</b>   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><b>Comment:</b></p>							
<b>Can patient take direction, retain and execute verbal OR written OR visual instructions?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Anticipated Progress:</b> √ the column matching anticipated independence by end of next rehab setting	<b>Independent with or without aids</b>	<b>Minimal assistance</b>	<b>Moderate to maximal assistance</b>				
Locomotion							
Transfers							
ADL							
Other (list)							
<p><b>Additional services:</b></p> <input type="checkbox"/> Pain management <input type="checkbox"/> Self care & mobility assessment prescription							

## 6. ABILITIES AND TOLERANCE - SPEECH

SLP to complete

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<b>Patient's Name</b>		<b>Date</b> <span style="float: right;">YYYY-MM-DD</span>	
<b>Tester:</b>		<b>Tester Phone</b>	
<b>Communication Disorder</b> <input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Both new and old	<b>Speech</b> <input type="checkbox"/> Adequate <input type="checkbox"/> Receptive aphasia <input type="checkbox"/> Expressive aphasia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Apraxia	<b>Communicates</b> <input type="checkbox"/> Adequately <input type="checkbox"/> With Difficulty <input type="checkbox"/> Unable	
<b>Changes in COMMUNICATION status in past week and implications for future rehab:</b>			
<b>Swallowing Disorder *</b> <input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Both new and old	<b>Phase swallowing affected</b> <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Oral <input type="checkbox"/> Both	<b>Has videofluoroscopy been performed on this admission?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Repeat/videoflouroscopy recommended?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Changes in SWALLOWING status in last week and implications for future rehab:</b>			
<b>Diet *</b> <input type="checkbox"/> Regular <input type="checkbox"/> NPO <input type="checkbox"/> PEG <input type="checkbox"/> NG	<b>Adjusted diet: solids</b> <input type="checkbox"/> Minced diet <input type="checkbox"/> Pureed diet <input type="checkbox"/> Dental soft diet <input type="checkbox"/> Snacks only <input type="checkbox"/> Other (list below):	<b>Adjusted diet: liquids</b> <input type="checkbox"/> Thin liquids <input type="checkbox"/> Nectar thick liquids <input type="checkbox"/> Honey thick liquids <input type="checkbox"/> Pudding <input type="checkbox"/> Sips of water only <input type="checkbox"/> G-tube feeds <input type="checkbox"/> Other (list below):	
<b>Changes in DIET in past week and implications for future rehab:</b>			
<b>Anticipated Progress:</b> √ the column matching anticipated level of independence by end of next rehab setting	<b>Independent with or without aids</b>	<b>Minimal assistance</b>	<b>Moderate to maximal assistance</b>
Communication			
Feeding			
<b>Impact of communication disorder(s) on behaviour</b> <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
<b>Speech, language and diet comments:</b>			

## 6. COGNITION AND BEHAVIOUR ASSESSMENT

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<b>Patient's Name</b>	<b>Date</b> <span style="float: right;">YYYY-MM-DD</span>
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<b>Tester</b>	<b>Phone</b>
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<b>Perceptual status</b> <input type="checkbox"/> Normal <input type="checkbox"/> Mild Inattention <input type="checkbox"/> Moderate Inattention <input type="checkbox"/> Severe Inattention <input type="checkbox"/> Body neglect <input type="checkbox"/> Reduced depth perception <input type="checkbox"/> Affected spatial awareness/skills <input type="checkbox"/> Apraxia
--

<b>Attention</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	<b>Memory *</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	<b>Judgment *</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	<b>Executive Functioning *</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test
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<b>Comments on COGNITION</b>  
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<b>In your opinion, rate the patient's progress in the past week</b> <input type="checkbox"/> Marked progress in the past week <input type="checkbox"/> Moderate progress in the past week <input type="checkbox"/> Minimal progress in the past week <input type="checkbox"/> Patient has plateaued in progress in the past week <input type="checkbox"/> Patient is too acute to measure progress in the past week <input type="checkbox"/> Other (comment)
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<b>Comment, RATE OF PROGRESS</b>  
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## 7. STROKE REFERRAL

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<b>Referring facility information</b>	
<b>Primary contact for information</b>	
<b>Your organization and/or program name</b>	
<b>Bed offer contact name and number/pager *</b>	
<b>Your fax number</b>	
<b>Date referral completed</b>	<b>YYYY-MM-DD</b>
<b>Anticipated date ready for rehab<sup>1</sup> or ready for transfer to rehab</b>	<b>YYYY-MM-DD</b>
<b>Comments, ready for rehab status</b>	
<b>Choose whether initial referral or update</b>	
<input type="checkbox"/> Initial referral <input type="checkbox"/> Update (responding to intake need for more information)	
<b>Rehab setting type</b>	
<input type="checkbox"/> Inpatient rehab HTSD or HTLD <input type="checkbox"/> Low Tolerance, long duration or LTLD	
<b>Planned referral destination/s</b>	
1.	2.
3.	4.
5.	6.
<b>Client preferred choice for referral</b>	
<b>Preferred accommodation *</b>	
<input type="checkbox"/> Ward <input type="checkbox"/> Private	<input type="checkbox"/> Semi private <input type="checkbox"/> Other
<b>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</b>	
<b>Additional referral comments</b>	

<sup>1</sup> Ready for rehab: Refer to Inpatient Rehab Referral Guidelines GTA Rehab Network 2005  
 Toronto Stroke Networks Last modified March 2, 2011  
 \* Electronic Referral cannot be made without completion of this field