**ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM**

# 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.**

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:**

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

**Optional attachments:**

✓ Social Work report
✓ Behavioural supplemental information

## ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

**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

GTA REHAB Network

# 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 INFO

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.**<br><br>**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 (specify):

**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

**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: _____

| Address: | City/Prov: | Postal Code: |
|---|---|---|
| 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)*

**Home living situation, living with:** *(Adapted from CIHI-NRS)*
☐ Spouse/Partner ☐ Living Alone
☐ Family (including extended family) ☐ Not applicable
☐ Others ☐ Unknown

**Pre-Admission Accommodation:**
☐ House ☐ Long-term Care Home ☐ Homeless/Hostel
☐ Apartment Building ☐ Rooming House ☐ Unknown
☐ Retirement Home ☐ Residential Group Home
☐ Other (Specify):

**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):

### FINANCES

**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: |
|---|---|---|
| Daytime Phone: | Evening Phone: | |

**Marital Status:**
☐ Single ☐ Separated ☐ Unknown
☐ Married ☐ Divorced
☐ Common Law ☐ Widowed

**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):

**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):

**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:**

**Weight:** ☐ 300 lbs (136 Kg) or more

**Smoker:** ☐ No ☐ Yes ☐ Independent/Safe

**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 (specify): _____

**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
☐ 02 at exercise: _____ L/min
☐ BIPAP
☐ Constant Oxygen: _____L/min
☐ 02 at rest: _____ L/min
☐ 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

To be completed by Nursing (cont'd)

**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<br>☐ Special Bed<br>☐ Special Mattress<br>☐ Other (specify): | **Equipment details/procedures:** |

**Bladder Management:** ☐ N/A

| | |
|---|---|
| ☐ Indwelling catheter<br>☐ Intermittent catheterization<br>☐ Condom catheter<br>☐ Using incontinent product<br>☐ Toileting assistance required<br>☐ Occasional incontinence<br>☐ Total incontinence<br>☐ Bladder retention/Bladder scanned | **Treatment details/procedures:** |

**Bowel Management:** ☐ N/A

| | |
|---|---|
| ☐ Toileting assistance required<br>☐ Occasional incontinence<br>☐ Total incontinence<br>☐ Using incontinent product | **Treatment details/procedures:** |

**Ostomy:** ☐ N/A ☐ Yes

| | |
|---|---|
| **Ability to care for ostomy:**<br>☐ Independent ☐ Total care<br>☐ 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 | ☐ Markham Stouffville Hospital | ☐ St. John's Rehab Hospital | ☐ West Park Healthcare Centre |
| ☐ Bridgepoint Health | ☐ Providence Healthcare | ☐ Toronto East General Hospital | ☐ William Osler Health Centre |
| ☐ Credit Valley Hospital | ☐ Rouge Valley Health System | ☐ Toronto Grace Health Centre | ☐ York Central Hospital |
| ☐ Halton Healthcare Services | ☐ Runnymede healthcare Centre | ☐ Toronto Rehab/UHN | ☐ Other (specify): |
| ☐ Lakeridge Health | ☐ Southlake Regional Health Centre | ☐ Trillium Health Centre | |

**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.