V2.1 Cluster 2 Acute Care to Rehab & Complex Continuing Care (CCC) Referral

Insert Health Service Provider Logo PRHC Peterborough Regional Health Centre	*Patient Identification* PATIENT LABEL

Referral Destination

☐ *Referral to Rehab: (Please check one)*

☐ HTSD / Regular stream ☐ LTLD/slowstream ☐ Either (Receiving facility to determine)

☐ *Referral to Complex Continuing Care (CCC) (For LTLD / slowstream rehab, select within Rehab Category above)*

If Faxed Include Number of Pages (Including Cover): _____ Pages

Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY

Patient Details and Demographics

Health Card #: Version Code: Province Issuing Health Card:

No Health Card #: ☐ No Version Code: ☐

Surname: Given Name(s):

No Known Address: ☐

Home Address: City: Province:

Postal Code: Country: Telephone: Alternate Telephone:
No Alternate Telephone: ☐

Current Place of Residence (Complete If Different From Home Address) :

Date of Birth: DD/MM/YYYY Gender: ☐ M ☐ F ☐ Other_____ Marital Status:

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ Other _____

Primary Alternate Contact Person:

Relationship to Patient (Please Check All Applicable Boxes): ☐ POA ☐ SDM ☐ Spouse ☐ Other_____

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Secondary Alternate Contact Person: None Provided: ☐

Relationship to Patient: ☐ POA ☐ SDM ☐ Spouse ☐ Other _____ (Please Check All Applicable Boxes)

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Insurance: N/A: ☐

For CCC Only - Co-Payment Discussed With: ☐ Patient ☐ Other_____

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Rehab/CCC Population Requested:

☐ ABI ☐ Amputee ☐ Burns ☐ Cardiac ☐ Chronic Ventilation ☐ General/Medical

☐ Geriatric ☐ MSK ☐ Neuro ☐ Oncology ☐ Respiratory Rehab ☐ Spinal Cord

☐ Stroke ☐ Trauma ☐ Transplant ☐ Other _____

Current Location Name: Current Location Address: City:

Province: Postal Code:

Current Location Contact Number: Bed Offer Contact Name: Bed Offer Contact Number:

Medical Information

Primary Health Care Provider (e.g. MD or NP) Surname: Given Name(s):

☐ None

Allergies: ☐ No Known Allergies ☐ Yes --- If Yes, List Allergies:

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify):_____

Admission Date: DD/MM/YYYY Date of Injury/Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Nature/Type of Injury/Event:

Primary Diagnosis:

Current Medical Issues:

Past Medical History:

Height: Weight:

Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No

☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____ Location: _____

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Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No
Frequency: _____ Duration:_____ Location: _____

Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No
Frequency: _____ Duration:_____ Location:_____

Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ No Details:

Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative; Palliative Performance Scale:_____ ☐ Unknown

Advanced Medical Directives:

Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other_____

Pending Investigations: ☐ Yes ☐ No Details:

Frequency of Lab Tests: _____ Unknown: ☐ None: ☐

Study Medications: ☐ Yes ☐ No Details:

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements ?: ☐ Yes ☐ No -- If No, Skip to Next Section

Supplemental Oxygen: ☐ Yes ☐ No Ventilator: ☐ Yes ☐ No

Special Oxygen Equipment/Human Resources required? (e.g. rebreather, Optiflow, specialized resources of Respiratory Therapist):
☐ No ☐ Yes (if Yes, Please Specify):

Breath Stacking: ☐ Yes ☐ No Insufflation/Exsufflation: ☐ Yes ☐ No

Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless Type: Size:

Suctioning: ☐ Yes ☐ No Frequency:

C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

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Additional Comments:

IV Therapy

IV in Use?: ☐ Yes ☐ No -- If No, Skip to Next Section

IV Therapy: ☐ Yes ☐ No Central Line: ☐ Yes ☐ No PICC Line : ☐ Yes ☐ No

Name of IV Medication:

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: _____

Skin Condition

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

1. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

2. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

3. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

* ***If additional wounds exist, add supplementary information on a separate sheet of paper.***

Continence

Is Patient Continent?: ☐ Yes ☐ No -- If Yes, Skip to Next Section

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Bladder Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Pain Care Requirements

Does the Patient Have a Pain Management Strategy?: ☐ Yes ☐ No -- If No, Skip to Next Section

Controlled With Oral Analgesics: ☐ Yes ☐ No

Medication Pump: ☐ Yes ☐ No

Methadone: ☐ Yes ☐ No

Epidural: ☐ Yes ☐ No

Has a Pain Plan of Care Been Started: ☐ Yes ☐ No

Communication

Does the Patient Have a Communication Impairment?: ☐ Yes ☐ No --If No, Skip to Next Section

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: _____

Delirium: ☐ Yes ☐ No -- If Yes, Cause/Details: _____

History of Diagnosed Dementia: ☐ Yes ☐ No

Behaviour

Are There Behavioural Issues?: ☐ Yes ☐ No -- If No, Skip to Next Section

Does the Patient Have a Behaviour Management Strategy: ☐ Yes ☐ No

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering
☐ Sundowning ☐ Exit-Seeking ☐ Resisting Care ☐ Other
☐ Restraints -- If Yes, Type/Frequency Details : _____

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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)						
Dressing: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						

Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No -- If No, Skip to Next Section

☐ HALO ☐ Orthosis (including splints, slings)

☐ Bariatric - If Yes, Please Describe Equipment Needs:_____

☐ Other:

Pleuracentesis: ☐ Yes ☐ No Drain: ☐ Yes ☐ No - If Yes, Type Details:_____

Paracentesis: ☐ Yes ☐ No Drain: ☐ Yes ☐ No - If Yes, Type Details:_____

Need for a Specialized Mattress: ☐ Yes ☐ No Negative Pressure Wound Therapy (NPWT): ☐ Yes ☐ No

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Rehab Specific

AlphaFIM® Instrument

Is AlphaFIM® Data Available: ☐ Yes ☐ No -- If No, Skip to Next Section

Has the Patient Been Observed Walking 150 Feet or More: ☐ Yes ☐ 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:		

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:**