Ontario
Waterloo Wellington Local Health Integration Network

Acute Care to Rehab & Complex Continuing Care (CCC) Referral

Low Intensity Rehab ☐ (GRH, SJHCG)
General Rehab ☐ (CMH, GRH, SJHCG)
Activation/Restoration ☐ (GMCH, Sunnyside Convalescent Care)
Stroke Rehab ☐ Ischemic ☐ Hemorrhagic
Chronic Assisted Ventilator ☐ (GRH only)
Complex Medical Management ☐ (GRH, SJHCG, GMCH)
Client #:
Program Readiness Date: _____
Fill Patient Data

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

Estimated Date of Rehab/CCC Readiness:

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: Gender: 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(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other _____
Telephone: Alternate Telephone: No Alternate Telephone:☐

Insurance: ☐ N/A Program Requested:

Current Location Name: Current Location Address: City:
Province: Postal Code:

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

FINAL Rehab and CCC Provincial Referral Standards for Provincial Implementation March 14, 2014
Alternate Level of Care Resource Matching & Referral Business Transformation Initiative (ALC RM&R BTI)
WW550 May 2019

Please Fax Completed Form to 519-742-0635

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Client #: DOB:
HCN: Version:

Medical Information

Primary Health Care Provider (e.g. MD or NP) Surname: Given Name(s):
☐ None

Reason for Referral:

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

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

Admission Date: Date of Injury/Event: Surgery Date:

Specific Patient Goals:

History of Falls: _____ in the last 30 days _____ in the last 31 - 90 days _____ in the last 91 - 180 days
Comments:

Nature/Type of Injury/Event:

Primary Diagnosis:

History of Presenting Illness/Course in Hospital:

Current Active Medical Issues/Medical Services Following Patient:

Past Medical History:

Height: Weight: Code Status:

Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____
Location: _____

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

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Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No Frequency: _____ Duration:_____
Location:_____
Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ No Details:

CCC / Convalescent Specific
Medical Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative ☐ Unknown Palliative Performance Scale:_____

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

Pending Investigations: ☐ Yes ☐ No Details:

Frequency of Lab Tests: _____ ☐ Unknown ☐ None
Date of last Chest x-ray: _____ ***Include in pkg**

Respiratory Care Requirements

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

Supplemental Oxygen: ☐ Yes ☐ No _____ L/Min Ventilator: ☐ Yes ☐ No
Breath Stacking: ☐ Yes ☐ No Insufflation/Exsufflation: ☐ Yes ☐ No
Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless
Suctioning: ☐ Yes ☐ No Frequency:
C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No
Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

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

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 Diet Type:

WW550 May 2019

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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.***
* **Include any specialist notes**

Continence

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

Bladder Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent
Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent
☐ Catheter Size: _____ ☐ Ostomy ☐ Ileostomy ***Patient pays own supplies for Convalescent Care**

Pain Care Requirements

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

Comments:

Controlled With Oral Analgesics: ☐ Yes ☐ No
Medication Pump: ☐ Yes ☐ No
Epidural: ☐ Yes ☐ No
Has a Pain Plan of Care Been Started: ☐ Yes ☐ No ***If Yes, Send Plan**

Communication

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

Communication Impairment Description:

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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:

☐ MOCA: _____ ☐ Delayed Recall: _____

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
☐ Sun downing ☐ ExitSeeking ☐ Resisting Care ☐ Other
☐ Restraints -- If Yes, Type/Frequency Details :

Mood:
☐ Verbal Expressions of Distress (i.e. negative statements, persistent anger, unrealistic fears, repetitive complaints/comments)
☐ Sleep Cycle Issues ☐ Sad, Apathetic, Anxious Appearance ☐ Loss of Interest

Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one ☐ Bed Alarm ☐ Chair Alarm

Social History

Discharge Destination: ☐ Multi-Storey ☐ Bungalow ☐ Apartment ☐ LTC
☐ Retirement Home (Name):

Accommodation Barriers: ☐ Unknown

Smoking: ☐ Yes ☐ No Details:

Alcohol and/or Drug Use: ☐ Yes ☐ No Details:

Previous Community Supports: ☐ Yes ☐ No Details:

Discharge Planning Post Hospitalization Addressed: ☐ Yes ☐ No Details:

Discharge Plan Discussed With Patient/SDM: ☐ Yes ☐ No

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Current Functional Status

Sitting Tolerance: ☐ More Than 2 Hours Daily ☐ 1-2 Hours Daily ☐ Less Than 1 Hour Daily ☐ Has not Been Up

Transfers: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Mechanical Lift

Ambulation: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Unable

Number of Metres: _____

Weight Bearing Status: ☐ Full ☐ As Tolerated ☐ Partial ☐ Toe Touch ☐ Non

Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2
☐ Zimmer Splint ☐ Cast ☐ Ambulation Aid: Specify:

Activities of Daily Living

Level of Function Prior to Hospital Admission (ADL & IADL) :

Current Status – Complete the Table Below: (Include information that demonstrates progress towards goals)

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)						

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Special Equipment Needs

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

☐ HALO ☐ Orthosis ☐ Bariatric ☐ Other_____

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

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 (levels 1-7):	Transfers: Bed, Chair_____	Expression_____	Transfers: Toilet_____
	Bowel Management _____	Locomotion: Walk_____	Memory_____
If No – Raw Ratings (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) and Notes to demonstrate goals progress

☐ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.) and lab work

☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology, any Psychologist or Psychiatrist Consult Notes if Behaviours are present, Wound)

Completed By: **Title:** **Date:**

Contact Number: **Direct Unit Phone Number:**