RESET FORM

Ontario Health atHome

Fax completed form to: 519-742-0635
Number of pages (including cover):

Add Patient Label Here

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

Attachment Checklist:

Please Include Documentation to Support Brief Notes On Application

- ☐ Demographic Information
- ☐ Letter of Understanding (Consent and Information Letter Provided)
- ☐ Relevant Progress Notes from last 7 days (May include OT, PT, SLP, RD, Nursing)
- ☐ Medical History/Consult Notes
- ☐ Medication Administration (to be sent at Bed Offer)

Program:

- ☐ Low Intensity Rehab (WRHN @Chicopee, SJHCG)
- ☐ General Rehab (CMH, WRHN @Chicopee, SJHCG)
- ☐ Stroke Rehab (CMH, WRHN @Chicopee, SJHCG):
  - ☐ Ischemic Hemorrhagic
- ☐ Complex Medical Management (WRHN @Chicopee, SJHCG)
- ☐ Chronic Assisted Ventilator (WRHN @Chicopee)

Patient Current Location (Hospital, Floor, Room/Bed):

Phone Number for Nursing Unit:

MEDICAL INFORMATION

Medically Stable:	☐ Y ☐ N (Medical issues have resolved/stabilized. There is no plan to change active treatment based on an actively changing condition.)

Primary Diagnosis:

Past Medical History:

History of Present Illness/Surgery:

Active Medical Issues:

Rehab Goals Appropriate to Program:

Follow-Up Appointments/Imaging:

CLINICAL INFORMATION

Vital Signs: Height: Code Status:

Febrile in last 72 hours: ☐ Y ☐ N Weight:

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Allergies: Other:
☐ No Known Allergies

Isolation Status: ☐ Clear ☐ C-Diff ☐ MRSA ☐ VRE Other:

COVID Status: Date Considered Resolved: COVID Vaccine Status:

Smoking Status:
Smoker: ☐ Y ☐ N
Currently smoking while in hospital: ☐ Y ☐ N
Willingness to abstain from smoking for duration of program: ☐ Y ☐ N

Hearing Impaired: ☐ Y ☐ N **Vision Impaired:** ☐ Y ☐ N

Speech/Communication: ☐ Aphasia/Dysarthria ☐ Difficulty Communicating ☐ Unable to Communicate
☐ Adequate Language:

Nutrition: ☐ Diet type: ☐ Enteral feeds:
☐ Standard Diet Texture: ☐ Dentures
Fluid Consistency: ☐ Swallowing concerns:

Bladder: ☐ Routine Toileting ☐ Occasionally Incontinent ☐ Incontinent
☐ Full Control ☐ Foley Catheter Change Due:

Bowel: ☐ Routine Toileting ☐ Occasionally Incontinent ☐ Incontinent
☐ Full Control Date of last BM:

Ostomy: ☐ Y ☐ N Specify:
☐ Independent with care ☐ Assistance with care ☐ Total care

IV Therapy: ☐ Y ☐ N
IV Antibiotics: ☐ Y ☐ N Frequency/Duration:
PICC Line: ☐ Y ☐ N Length:

Dialysis: ☐ Y ☐ N Frequency/Duration:

Radiation: ☐ Y ☐ N

Chemotherapy: ☐ Y ☐ N Frequency/Duration:

Skin Condition: ☐ Rashes ☐ Incision ☐ Requires Positioning
☐ Normal ☐ Open Sores ☐ Dressings ☐ Requires Foot Care
☐ Decubitus Ulcers ☐ VAC Dressing ☐ Burns
Attached supporting document including specific interventions:
(e.g. NSWOC note, nursing note, wound care intervention)

Special Needs: ☐ Special Bed: ☐ Special Equipment:
☐ N/A

RESPIRATORY CARE REQUIREMENTS

Supplemental Oxygen	☐ Y ☐ N	Route:	Rate:	L/Min
Home Oxygen	☐ Y ☐ N			
Insufflation/Exsufflation:	☐ Y ☐ N	Breath Stacking	☐ Y ☐ N	

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Tracheostomy	☐ Y ☐ N	☐ Cuffed	☐ Cuffless			
Suctioning	☐ Y ☐ N	Frequency:				
CPAP	☐ Y ☐ N	Patient Owned:	☐ Y ☐ N			
BiPAP	☐ Y ☐ N	Rescue Rate:	☐ Y ☐ N	Patient Owned:	☐ Y ☐ N	
Additional Comments:						

THERAPY INFORMATION

Cognition
WNL= Within Normal Limits I= Impaired

	WNL	I	Comments
Cognitive Function			
MoCA Score			
Ability to Learn/Retain Information			

Responsive Behaviours: ☐ Y ☐ N
☐ Exit seeking/Wandering
☐ Need for constant observation
☐ Aggression (Verbal/Physical)
☐ Resisting care

ADL Function
Ind= Independent SU= Setup Only S= Supervision A= Assistance

	Ind	SU	S	A	Comments (Min/Mod/Max A/x1/x2 Baseline)
Feeding					
Grooming					
Dressing					
Toileting					
Bathing					

Mobility Function
Ind= Independent SU= Setup Only S= Supervision A= Assistance

	Ind	SU	S	A	Comments (Min/Mod/Max A/x1/x2 Baseline)
Supine <~> Sit					
Bed <~> Chair					
Ambulation					
Stairs					

Falls History: ☐ Y ☐ N
in the last 7 days:
in the last 30 days:
Bed/Chair Alarm: ☐ Y ☐ N
Other:

Weight Bearing Status:

Current Mobility Aid:

Prior Mobility Aid:

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Current Distance Ambulating:

Movement Restrictions/Activity Orders:

Current Equipment Needs:

DISCHARGE PLAN (FOLLOWING REHABILITATIVE CARE)

Has the discharge plan been initiated? ☐ Y ☐ N

If yes, discharge to: ☐ Home Independently ☐ Home with Support

Home setup (i.e. multilevel, apartment, etc.):

☐ RH: ☐ LTCH:

Has the home been notified of patient's return? ☐ Y ☐ N

Prior Home Care Supports:

Are discharge concerns anticipated? ☐ Y ☐ N

Describe:

CONTACT INFORMATION

Bed Offer Contact Name:	Bed Offer Contact #:

Contributor	Designation	Contact #	Date

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LETTER OF UNDERSTANDING

_____(insert patient's name), your current care needs no longer require an acute hospital setting. The health care team has that your needs may be med within the services offered in a rehabilitative care program. These programs are regional programs, offered at multiple sites within Waterloo Wellington:

- ☐ General Rehabilitation
- ☐ Stroke Rehabilitation
- ☐ Low Intensity Rehabilitation
- ☐ Complex Medical Management
- ☐ Chronic Ventilator / Respiratory Program

Site	General Rehab	Stroke Rehab	Low Intensity Rehab	Complex Medical Management	Chronic Ventilator / Respiratory Program
Waterloo Regional Health Network @Chicopee in Kitchener	✓	✓	✓	✓	✓
St. Joseph's Health Centre in Guelph	✓	✓	✓	✓	

Referrals are coordinated by Ontario Health atHome Waterloo Wellington. Your health care team will be sharing your medical and personal information with Ontario Health atHome WW and the rehabilitative care program. Ontario Health atHome WW will add your name to the waiting list. Your initials and gender will be accessible to Ontario Health atHome WW's other hospital partners.

You will be notified by your health care team when a bed becomes available for you. The first available bed may be located at any one of the locations listed above. The health care team will assist you to arrange the transfer to the Rehabilitation program.

I have reviewed and understand the above information. I agree to proceed with the rehabilitative care program referral process. I understand that my personal and health information will be shared with Ontario Health atHome WW and the rehabilitative care sites within the region.

Patient Name:

Patient/Substitute Decision Maker's (SDM) Signature:

Print SDM Name: Date:

Verbal/telephone agreement Documentation (if signature not possible)

Consent Obtained From: Date:

Signature of Staff Member:

Printed Name of Staff Member obtaining consent: