Ontario Health atHome

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

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

If Faxed include Number of Pages (Including Cover): _____ pages **Fill Patient Data**

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 POA ☐ SDM ☐ Spouse ☐ Other ☐			
Telephone	Alternate Telephone	No Alternate Telephone ☐	
Secondary Alternate Contact Person			
Relationship to Patient 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 #	

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)

Ontario Health atHome

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Medical Information

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

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 No ☐ Yes ☐ Peritoneal ☐ Hemodialysis ☐	Freq/Days

Location

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Is Patient Currently Receiving Radiation Therapy	No ☐ Yes ☐	Frequency	Duration
Location			
Concurrent Treatment Requires Off-Site	No ☐ Yes ☐	Details	
CCC/Convalescent Specific Medical Prognosis	Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative ☐ Unknown ☐ PPS:		
Services Consulted	PT ☐ OT ☐ SW ☐ SLP ☐ Nutrition ☐ Other:		
Pending Investigations	No ☐ Yes ☐ Details:		
Frequency of Lab Tests	None ☐ Unknown ☐	Date of last Chest Xray	***incl in pkg.***

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements Yes ☐ No ☐ ***(If no, Skip to Next Section)***

Supplemental Oxygen	No ☐ Yes ☐	L/Min	Ventilator No ☐ Yes ☐
Breath Stacking	No ☐ Yes ☐	Insufflation/Exsufflation No ☐ Yes ☐	
Tracheostomy	No ☐ Yes ☐	Cuffed ☐ Cuffless ☐	
Suctioning	No ☐ Yes ☐	Frequency	
C-PAP	No ☐ Yes ☐	Patient Owned No ☐ Yes ☐	
Bi-PAP	No ☐ Yes ☐	Rescue Rate No ☐ Yes ☐	Patient Owned No ☐ Yes ☐
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 Details	
TPN Yes ☐ (If Yes Include Prescription with Referral	No ☐
Enteral Feeding Yes ☐ No ☐	Diet Type

FINAL Rehab and CCC Provincial Referral Standards for Provincial Implementation March 14, 2014

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Ontario Health atHome

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

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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 (e.g., NPWT or VAC)		Frequency	
Time to Complete Dressing	☐ Less than 30 minutes	☐ Greater than 30 minutes	
2. Location		Stage	
Dressing Type (e.g., NPWT or VAC)		Frequency	
Time to Complete Dressing	☐ Less than 30 minutes	☐ Greater than 30 minutes	
3. Location		Stage	
Dressing Type (e.g., NPWT or VAC)		Frequency	
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 no, 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 Requirements

Does the Patient have a Pain Management Strategy **Yes** ☐ **No** ☐ ***(If no, Skip to Next Section)***

Controlled with Oran Analgesics	Yes ☐ No ☐	Comments
Medication Pump	Yes ☐ No ☐	Comments
Epidural	Yes ☐ No ☐	Comments
Has a Pain Plan of Care Been Started?	Yes ☐ ****If Yes Send Plan*** No ☐	Comments

Communication

Does the Patient have a Communication Impairment **Yes** ☐ **No** ☐ ***(If no, Skip to Next Section)***

Communication Impairment Description

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)

Ontario Health atHome

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

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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 ☐**	
Details	
MOCA ☐	Delayed Recall ☐
Delirium No ☐ Yes ☐	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 ☐	Exit Seeking ☐	Resisting Care ☐	Other ☐
	Restraints ☐ If Yes, Type/Frequency			
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 ☐			
Accommodation Barriers Unknown ☐	Details			
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 ☐	None ☐
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 ☐ (Specify)

Pleurocentesis 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	Locomotion: Walk	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, Xray, US etc.) and lab work
- ☐ Relevant Consultation Reports (e.g., PT, OT, SLP, Psychologist or Psychiatrist Consult Notes if Behaviours are present, Wound)

Completed by	Title	Date
Contact Number	Direct Unit Phone Number	