

Name: _____

Hospital Number: _____

Phone Number: _____

PSFDH INPATIENT REHABILITATION PROGRAM REFERRAL FORM (External)

Admission Criteria:

1. Medically stable
2. Require at least two allied health services
3. Must be able to tolerate a minimum of two 30 min therapy sessions daily
4. Cognitive capacity to be able to follow simple commands, demonstrate ability to learn, demonstrate carry over day to day
5. Patient in agreement to participate in the rehab program: i.e.: motivation to improve
6. Must have guarantee that patient will be repatriated to home hospital if not able to participate in rehab (e.g.: becomes medically unstable, plateaus before meeting goals, does not show improvement after 3 week trial, discharge disposition to LTC or unknown)

Eligible Conditions include:

- Stroke
- Other neurological conditions (e.g.: MS, GBS, PD)
- Acute rehab post LE amputation: do not provide inpatient prosthetic training
- MSK: post arthroplasty, trauma, etc.
- Deconditioning
- Patients with TBI and SCI may be considered for admission, depending on complexity of the individuals needs.

REFERRAL INFORMATION

Referral Date

Referral facility and unit

Referring MRP/Contact phone number

Referral form completed by:

Contact Number:

PATIENT DEMOGRAPHICS

Name:

DOB:

AGE:

GENDER: M/F

Primary Care Provider:

Home Address:

Phone Number:

Cell:

Other:

Contact Person/Relationship/phone number:

SDM (if required):

Primary language:

Name: _____

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CLINICAL PROFILE		
Primary Diagnosis:		
Reason for referral:		
History of presenting illness/course in hospital:		
Current Active Medical Issues:		
Past Medical History:		
BASELINE STATUS PRIOR TO ADMISSION		
Independent for ADL's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Mobility (eg: aids, stairs, orthotics):		
Independent for iADL's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Cognitive Status (eg: Hx of dementia):		
Employed/Retired:		
Active driver's license	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Living arrangements (home, RH, LTC):		
Potential caregiver at home:		
Homecare or other services		
CURRENT FUNCTIONAL STATUS		
Impairments/deficits:		
Activity Tolerance:		
Bed Mobility:		
Sitting balance:		
Transfers:		
Ambulation:		
Weight bearing status/#weeks:		
Bladder Continence:		
Bowel Continence:		
Skin Integrity/wounds		
Speech		
Swallow		
ADL's		
iADL's		
Cognition		
Carry over/ability to learn		
Mood		
Behavioral Concerns		
Pain Care requirements		
Has MOT been notified <input type="checkbox"/> Yes <input type="checkbox"/> No		

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ASSESSMENT SCALES COMPLETED/DATE	
Alpha-FIM	
MoCA/mini Cog	
Berg	
PHQ-9/other mood screens	
Visual Perceptual Screens	
Bedside swallow/VFSS	
Other:	
SPECIAL EQUIPMENT NEEDS	
Bariatric (weight>250 lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mechanical Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enteral Feeds (G-tube/NG)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foley	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pressure Relief Mattress	<input type="checkbox"/> Yes <input type="checkbox"/> No
C-PAP	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trach	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	
PATIENT/FAMILY GOALS	
Describe:	
READINESS FOR REHAB	
Medically Stable:	<input type="checkbox"/> Yes <input type="checkbox"/> No
IPAC Status	
Outstanding medical investigations:	
Outstanding medical/surgical procedures:	
Follow up appointments:	
DISPOSITION	
Tentative/Anticipated destination:	
Referring Facility has agreed to repatriation if required:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please fax completed form to: Rehabilitation Senior Occupational Therapist, PSFDH

Fax Number: 613-267-3964

Once the Referral form has been reviewed, the PSFDH Senior Physiotherapist will reach out to the Referring Facility's Contact Person within 2 days for further discussion.

Senior Occupational Therapist Contact Phone Number: 613-267-1500 x4722