

<i>Insert Health Service Provider Logo</i>	Patient Identification
Referral Destination	
IDENTIFY REFERRAL DESTINATION: <u>Bedded Level of Rehabilitative Care</u> <input type="checkbox"/> Rehabilitation – High Intensity <input type="checkbox"/> Complex Medical Management- Short Term <input type="checkbox"/> Rehabilitation – Low Intensity <input type="checkbox"/> Complex Medical Management- Long Term <input type="checkbox"/> Activation/Restoration – Hospital based/Other <input type="checkbox"/> Activation/Restoration – Convalescent Care (<u>REFER THROUGH ONTARIO HEALTH @HOME</u>)	<u>Complex Continuing Care (CCC)</u> <input type="checkbox"/> Other programs (specify): _____ If Faxed Include Number of Pages (Including Cover): _____ Pages
Estimated Date of Rehabilitative Care/CCC Readiness: _____ DD/MM/YYYY	
Patient Details and Demographics	
Health Card #: _____	Version Code: _____
No Health Card #: <input type="checkbox"/>	No Version Code: <input type="checkbox"/>
Province Issuing Health Card: _____	
Surname: _____	Given Name(s): _____
No Known Address: <input type="checkbox"/>	
Home Address: _____	City: _____
Postal Code: _____	Province: _____
Country: _____	Telephone: _____
	Alternate Telephone: _____
No Alternate Telephone: <input type="checkbox"/>	
Current Place of Residence (Complete If Different from Home Address): _____	
Date of Birth: _____ DD/MM/YYYY	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____
Marital Status: _____	
Patient Speaks/Understands English: <input type="checkbox"/> No <input type="checkbox"/> Yes Interpreter Required: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other _____	
Primary Alternate Contact Person: _____	
None Provided: <input type="checkbox"/>	
Relationship to Patient (Please Check All Applicable Boxes): <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
Telephone: _____	Alternate Telephone: _____
No Alternate Telephone: <input type="checkbox"/>	
Secondary Alternate Contact Person: _____	
None Provided: <input type="checkbox"/>	
Relationship to Patient: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
(Please Check All Applicable Boxes)	
Telephone: _____	Alternate Telephone: _____
No Alternate Telephone: <input type="checkbox"/>	

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Responsibility for Payment: Insurance: _____ N/A: <input type="checkbox"/> <input type="checkbox"/> OHIP <input type="checkbox"/> Federal Government <input type="checkbox"/> IFH (Interim Federal Health Coverage) <input type="checkbox"/> Inter-provincial Insurance Plan <input type="checkbox"/> Insured/Self Pay <input type="checkbox"/> Other Payment Sources <input type="checkbox"/> WSIB <input type="checkbox"/> Uninsured/Self Pay <input type="checkbox"/> Unknown	
Preferred accommodation: <input type="checkbox"/> Ward <input type="checkbox"/> Semi-private <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	
For CCC Only - Co-Payment Discussed With: <input type="checkbox"/> Patient <input type="checkbox"/> Other _____	
Rehabilitative Care/CCC Population Requested: <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> Chronic Ventilation <input type="checkbox"/> General/Medical <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neuro <input type="checkbox"/> Oncology <input type="checkbox"/> Respiratory Rehab <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Stroke <input type="checkbox"/> Trauma <input type="checkbox"/> Transplant <input type="checkbox"/> Other _____	
Current Location Name: _____ Current Location Address: _____ City: _____ Province: _____ Postal Code: _____	
Current Location Contact Number: _____ Ext. _____ Bed Offer Contact Name: _____ Bed Offer Contact Number: _____ Ext. _____	
Is the patient in police/correctional services custody? <input type="checkbox"/> No <input type="checkbox"/> Yes If there is an ongoing criminal investigation related to this admission, specify: Detective Name: _____ Contact Number: _____ Ext. _____	
Medical Information	
Primary Health Care Provider (e.g. MD or NP) <input type="checkbox"/> None Surname: _____ Given Name(s): _____	
Allergies: <input type="checkbox"/> No Known Allergies <input type="checkbox"/> Yes --- If Yes, List Allergies: (i.e., medication, food, other)	
Infection Control: <input type="checkbox"/> None <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CDIFF <input type="checkbox"/> ESBL <input type="checkbox"/> TB <input type="checkbox"/> COVID-19 (Specify details on next page) <input type="checkbox"/> Other (Specify)	

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COVID-19: Date considered positive: _____ DD/MM/YYYY Anticipated date to be recovered: _____ DD/MM/YYYY	List of symptoms:	
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: _____	
Provide the following: Medication: <input type="checkbox"/> MAR or list of medications attached Lab Work: <input type="checkbox"/> If indicated, send most recent lab work (e.g. Haemoglobin, white blood cell count, lytes, creatinine)		
Psychiatric Information		
Does patient have an active mental health history? (i.e., any issue being actively treated in hospital such as medication adjustment, new symptoms etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: _____		
		Attach the following: <input type="checkbox"/> Psychiatric notes
Diagnosis: _____		
Is the patient stable? <input type="checkbox"/> No <input type="checkbox"/> Yes		

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Medications previously taken for mental health issue:	
Reason seen/presenting symptoms:	
Current care plan (e.g., who is involved, frequency, strategies in place):	
Plan for ongoing follow-up (e.g., link to outpatient services or community follow up)	
Dialysis Information	
Is Patient Currently Receiving Dialysis: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis Frequency/Days: _____ Location: _____	
If Dialysis Centre is located off-site from rehab/CCC, indicate how patient will access Dialysis Centre: <input type="checkbox"/> Family drives <input type="checkbox"/> Volunteer drives <input type="checkbox"/> Wheel-Trans <input type="checkbox"/> Other _____	
Is the patient post-transplant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify details of follow-up: _____	
Oncology Information	
Is Patient Currently Receiving Chemotherapy: <input type="checkbox"/> No If patient is expected to receive chemotherapy, expected start date: _____ DD/MM/YYYY	
Is Patient Currently Receiving Chemotherapy: <input type="checkbox"/> Yes Frequency: _____ Duration: _____	
Location: _____ Details of how chemotherapy is tolerated: _____	
Is Patient Currently Receiving Radiation Therapy: <input type="checkbox"/> No If patient is expected to receive radiation, expected start date: _____ DD/MM/YYYY	
Is Patient Currently Receiving Radiation Therapy: <input type="checkbox"/> Yes Frequency: _____ Duration: _____	
Location: _____ Details of how radiation is tolerated: _____	
For neuro-oncology referrals seeking inpatient rehab prior to the beginning of oncology treatment: Are the pathology results back? <input type="checkbox"/> No If no, what is the most likely type of tumor based on radiology findings? _____ <input type="checkbox"/> Yes <input type="checkbox"/> Pathology report attached	

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Oncology Primary Contact Person (e.g., Oncologist, NP): _____ <input type="checkbox"/> N/A	
Concurrent Treatment Requirements Off-Site: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, is there a plan for how patient will get to/from appointment? <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	
Prognosis: <input type="checkbox"/> < 6 months <input type="checkbox"/> 6 - 12 months <input type="checkbox"/> >12 months If palliative, please provide PPS score: _____	
Advanced Medical Directives:	
Services Consulted: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SW <input type="checkbox"/> Speech and Language Pathology <input type="checkbox"/> Nutrition <input type="checkbox"/> Other _____	
Pending Investigations: <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	
Frequency of Lab Tests: _____ Unknown: <input type="checkbox"/> None: <input type="checkbox"/>	
Study Medications: <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	
Respiratory Care Requirements	
Does the Patient Have Respiratory Care Requirements? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes	
Was the patient intubated as part of their care? <input type="checkbox"/> No <input type="checkbox"/> Yes Number of days _____	
Supplemental Oxygen: <input type="checkbox"/> No <input type="checkbox"/> Yes Ventilator: <input type="checkbox"/> No <input type="checkbox"/> Yes Chest Tube: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Target O2 Sat _____ % <input type="checkbox"/> Intermittent Oxygen _____ L/min <input type="checkbox"/> Constant Oxygen _____ L/min <input type="checkbox"/> O2 at rest _____ L/min <input type="checkbox"/> O2 at exercise _____ L/min	
Special Oxygen Equipment/Human Resources required? (e.g. rebreather, Optiflow, specialized resources of Respiratory Therapist): <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please specify): _____	
Breath Stacking: <input type="checkbox"/> No <input type="checkbox"/> Yes Insufflation/Exsufflation: <input type="checkbox"/> No <input type="checkbox"/> Yes	

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Tracheostomy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Cuffed <input type="checkbox"/> Cuffless Type: _____ Is humidification required? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: _____ Is humidification heated? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify: _____ Who will change tracheostomy? <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> ENT <input type="checkbox"/> Other _____ Next change date for tracheostomy: _____ DD/MM/YYYY	
Suctioning: <input type="checkbox"/> No <input type="checkbox"/> Yes Frequency: <input type="checkbox"/> q 1- 2 hrs <input type="checkbox"/> q 2 - 3 hrs <input type="checkbox"/> q 3 - 4 hrs <input type="checkbox"/> q 8 - 12 hrs C-PAP: <input type="checkbox"/> No <input type="checkbox"/> Yes Patient Owned: <input type="checkbox"/> No <input type="checkbox"/> Yes Is patient independent with equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes Are these new settings from acute care admission? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify follow-up plan with Respirologist: _____	
Bi-PAP: <input type="checkbox"/> No <input type="checkbox"/> Yes Rescue Rate: <input type="checkbox"/> No <input type="checkbox"/> Yes Bi-PAP Settings: _____ Is patient independent with equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes Are these new settings from acute care admission? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify follow-up plan with Respirologist: _____	
How involved is the Respiratory Therapist? Additional Comments:	
IV Therapy	
IV in Use? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes	
IV Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Central Line: <input type="checkbox"/> No <input type="checkbox"/> Yes PICC Line: <input type="checkbox"/> No <input type="checkbox"/> Yes Port-A-Cath: <input type="checkbox"/> No <input type="checkbox"/> Yes Name of IV Medication:	
Hearing/Vision	
Hearing: <input type="checkbox"/> Intact, can hear routine conversation <input type="checkbox"/> Intact, with hearing aid <input type="checkbox"/> Reduced hearing <input type="checkbox"/> Completely impaired <input type="checkbox"/> American Sign Language	
Vision: <input type="checkbox"/> Intact <input type="checkbox"/> Intact with visual aid <input type="checkbox"/> Visual field deficit <input type="checkbox"/> Double vision <input type="checkbox"/> Completely impaired	

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Falls	
Does Patient Have a History of Falls? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes	
If yes, specify: <input type="checkbox"/> home/community <input type="checkbox"/> hospital	
History & Frequency: <input type="checkbox"/> Frequent <input type="checkbox"/> Rare <input type="checkbox"/> Intermittent	
Reason for most recent fall(s):	
<input type="checkbox"/> Balance <input type="checkbox"/> Vision <input type="checkbox"/> Strength <input type="checkbox"/> Fatigue <input type="checkbox"/> Decreased insight/judgment <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (list):	
Skin Condition	
Surgical Wounds and/or Other Wounds Ulcers? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes	
1. Location: _____ Stage: _____ Size: _____ (LxWxD in cm)	
Wound Care Orders: (e.g. Negative Pressure Wound Therapy or VAC) Frequency:	
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
2. Location: _____ Stage: _____ Size: _____ (LxWxD in cm)	
Wound Care Orders: (e.g. Negative Pressure Wound Therapy or VAC) Frequency:	
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
3. Location: _____ Stage: _____ Size: _____ (LxWxD in cm)	
Wound Care Orders: (e.g. Negative Pressure Wound Therapy or VAC) Frequency:	
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
* If additional wounds exist, add supplementary information on a separate sheet of paper.	

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Continance	
Is Patient Continent? <input type="checkbox"/> No - please describe below <input type="checkbox"/> Yes--- If Yes, Skip to Next Section	
Bladder Continent: <input type="checkbox"/> No <input type="checkbox"/> Yes If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent	
Bowel Continent: <input type="checkbox"/> No <input type="checkbox"/> Yes If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent	
Ostomy: <input type="checkbox"/> N/A <input type="checkbox"/> Yes Type/brand and care/products required _____	
Ability to care for ostomy: <input type="checkbox"/> Independent <input type="checkbox"/> Total care <input type="checkbox"/> Requires supervision	
Pain Care Requirements	
Does the Patient Have a Pain Management Strategy? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes (specify below)	
Controlled With Oral Analgesics: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Medication Pump: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Methadone: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Epidural: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Has a Pain Plan of Care Been Started? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Special Equipment Needs	
Special Equipment Required? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes	
<input type="checkbox"/> HALO <input type="checkbox"/> Orthosis (including splints, slings)	
<input type="checkbox"/> Bariatric -- If Yes, Please Describe Equipment Needs: (e.g., size, abdominal girth) _____	
<input type="checkbox"/> Other: _____	
Pleuracentesis: <input type="checkbox"/> No <input type="checkbox"/> Yes Drain: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes, Type Details: _____	
Paracentesis: <input type="checkbox"/> No <input type="checkbox"/> Yes Drain: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes, Type Details: _____	
Need for a Specialized Mattress: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify: _____	

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Swallowing and Nutrition
Swallowing Deficit: <input type="checkbox"/> No <input type="checkbox"/> Yes Swallowing Assessment Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes Is swallowing assessment needed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when: _____
Type of Swallowing Deficit Including any Additional Details: TPN: <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes, include prescription with referral.
Enteral Feeding: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Tube Type: _____ <input type="checkbox"/> Specify Formula Type & Rate of Feeds: _____
Therapeutic Diet Type: <input type="checkbox"/> Regular <input type="checkbox"/> Kosher <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal <input type="checkbox"/> Low Sodium <input type="checkbox"/> Other (specify): _____
Diet Texture: <input type="checkbox"/> Regular <input type="checkbox"/> Other (specify): _____
Dietitian Progress and Plan: _____

Communication
Does the Patient Have a Communication Impairment? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes (specify below)
Communication Impairment Description:

Cognition
Cognitive Impairment: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> No – If No, specify details below. <input type="checkbox"/> Yes

Cognitive Status (Complete Table Below)	Not Tested	Intact	Impaired
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):

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Able to follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Memory (short term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Memory (long term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Frustration Tolerance (ABI only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
<input type="checkbox"/> MMSE Score: _____ or <input type="checkbox"/> MoCA Score: _____	<input type="checkbox"/>	If did not/unable to complete, please explain:	
Rancho Los Amigos Cognitive Scale at present: (ABI only): _____			
Delirium: <input type="checkbox"/> No <input type="checkbox"/> Yes -- If Yes, Cause/Details: _____			
History of Diagnosed Dementia: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Responsive Behaviours			
Does the patient exhibit responsive behaviours? <input type="checkbox"/> No – If No, Skip to Next Section <input type="checkbox"/> Yes			
Does the Patient Have a Behaviour Management Strategy OR Behaviour Care Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify each of the following below:			
Strategies being used: (i.e., what is working/what did not work; does patient require close observation by staff; how long has plan been in place)			
Resources involved in developing care plan:			
Use of restraints -- If Yes, Type/Frequency Details:			
Use of sitter – If Yes, When/Frequency Details:			
Additional resources being used (i.e., family members, remote monitoring)			

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<p>Responsive Behaviours/Personal Expressions: Responsive behaviours or personal expressions are often used as forms of meaningful communication, often of unmet needs and/or emotions. Describing these responsive behaviours and personal expressions helps others to understand the patient more fully.</p> <p><input type="checkbox"/> Verbal (e.g., crying, grunting, yelling, humming, asking questions repeatedly, cursing, disinhibited)</p> <ul style="list-style-type: none"> • Describe responsive behaviours/personal expressions: _____ _____ • Under what conditions does it occur: _____ _____ • When: _____ <p><input type="checkbox"/> Physical (e.g., banging, kicking, collecting, fidgeting, grabbing, spitting, pacing)</p> <p><input type="checkbox"/> Declines/Fearful of Care</p> <p><input type="checkbox"/> Wandering</p> <ul style="list-style-type: none"> • Is patient easily redirected? <input type="checkbox"/> No <input type="checkbox"/> Yes <p><input type="checkbox"/> Exit-Seeking</p> <p><input type="checkbox"/> Other</p>	
<p>Level of Security: <input type="checkbox"/> Non-Secure Unit <input type="checkbox"/> Secure Unit <input type="checkbox"/> Wander Guard</p>	
Social History	
<p>Discharge Destination: <input type="checkbox"/> Multi-Storey <input type="checkbox"/> Bungalow <input type="checkbox"/> Apartment <input type="checkbox"/> LTC <input type="checkbox"/> Retirement Home (Name): _____</p>	
<p>Accommodation Barriers: <input type="checkbox"/> Unknown</p>	
<p>Smoking: <input type="checkbox"/> No <input type="checkbox"/> Yes Details: _____</p>	
<p>Alcohol and/or Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes Details: _____</p>	
<p>Previous Community Supports: <input type="checkbox"/> No <input type="checkbox"/> Yes Details: _____</p>	
<p>Discharge Planning Post Hospitalization Addressed: <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify details below)</p>	
<p>Discharge Plan Discussed with Patient/SDM: <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify details below)</p>	

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Current Functional Status	
Patient Goals (Please Indicate Specific, Measurable Goals):	
Participation Level: What is current maximum participation level? On average, patient is able to participate in _____ therapy sessions / day, _____ times / week for _____ minutes / session If the participation level is limited due to caseload demands, is tolerance anticipated to be longer with increased resources? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, can the patient tolerate ≥30 minutes for 2x/day? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Sitting Tolerance: <input type="checkbox"/> More Than 2 Hours Daily <input type="checkbox"/> 1-2 Hours Daily <input type="checkbox"/> Less Than 1 Hour Daily <input type="checkbox"/> Has not Been Up	
Transfers: Transfers prior to hospital admission: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Mechanical Lift Assistive Device used prior to hospital admission: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)_____	
Current Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Mechanical Lift Current Assistive Device: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)_____	
Ambulation: Ambulation prior to admission to hospital: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Unable Assistive Device used prior to hospital admission: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)_____	
Current Ambulation: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Unable Current Assistive Device <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)_____	
Other comments: _____	
Extended stay in hospital: Was there a delay in initiating the referral? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, please provide the context for the delay (e.g. deconditioned due to ICU stay or prolonged course of medical treatment etc.)	

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Stairs:
 Stairs prior to hospital admission: None Assist x1 Assist x2 Stair Lift/Glider
 Current ability to climb Stairs: Not Assessed Independent Supervision Assist x1 Assist x2 Stair Lift/Glider
 Articulate goals of rehab in relation to ambulation/stairs (i.e. number of stairs in discharge destination): _____

Braces/Orthosis:
 Jewitt Aspen Collar Zimmer Other (specify): _____
 To be worn during the following activities: In bed When in upright position During ambulation At all times

Weight Bearing Status:
Left: U/E L/E
 Full As Tolerated Partial _____% Toe Touch Non Date expected to be Full weight-bearing _____
DD/MM/YYYY
Right: U/E L/E
 Full As Tolerated Partial _____% Toe Touch Non Date expected to be Full weight-bearing _____
DD/MM/YYYY

Limbs:
Left: U/E impairment L/E impairment Aid(s) Required: _____
Right: U/E impairment L/E impairment Aid(s) Required: _____

Bed Mobility: Independent Supervision Assist x1 Assist x2

Activities of Daily Living

Describe baseline level of function 2 weeks prior to admission/illness onset (e.g., what is the change between baseline and current state across the physical, cognitive, functional, and psychosocial domains, ADL & IADL):

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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)						

Rehabilitative Care Specific AlphaFIM® Instrument

Is AlphaFIM® Data Available? No – If No, Skip to Next Section Yes

Has the Patient Been Observed Walking 150 Feet or More: NO Yes

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 _____

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Projected:	FIM® projected Raw Motor (13):	FIM® projected Cognitive (5):	
	Help Needed:		
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Attachments			
Details on Other Relevant Information That Would Assist With This Referral:			
Please indicate which of the following has been included with this referral: <ul style="list-style-type: none"> <input type="checkbox"/> Admission History and Physical <input type="checkbox"/> Relevant Assessments (Behavioural, Wound Care, PT, OT, SLP, SW, Nursing, Physician) <input type="checkbox"/> All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.) <input type="checkbox"/> Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present) <input type="checkbox"/> None 			
Completed By:	Title:	Date:	DD/MM/YYYY
Contact Number:	Ext:	Direct Unit Phone Number:	Ext:
Note: For faxed referrals, send the referral(s) directly to the program/service requested as per the organization's intake process. Information on the application process is available on Rehab Finder .			