Hôpital Régional de Pembroke Regional Hospital

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

Identify Referral Destination: ☐ *Referral to Rehab*
☐ *Referral to Complex Continuing Care (CCC)*

Patient Identification

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

Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY

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: DD/MM/YYYY Gender: M F Other Marital Status:

In which of the two official languages is the patient most comfortable receiving health services? English French
What is the patient's mother tongue? English French Other Interpreter Required: Yes No

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: ☐

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

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

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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: DD/MM/YYYY Date of Injury/Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Rehab Specific Patient Goals:

CCC Specific Patient Goals:

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:

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 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

Respiratory Care Requirements

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

Supplemental Oxygen: Yes No 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

Please Include Any Special Diet Concerns:

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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. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: Less Than 30 Minutes	Greater Than 30 Minutes
2. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: Less Than 30 Minutes	Greater Than 30 Minutes
3. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy 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*.**

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

Pain Care Requirements

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

Controlled With Oral Analgesics: Yes No

Medication Pump: Yes No

Epidural: Yes No

Has a Pain Plan of Care Been Started: Yes No

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:
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 ☐ Exit-Seeking ☐ Resisting Care ☐ Other ☐ Restraints -- If Yes, Type/Frequency Details :
Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one
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

Activities of Daily Living

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

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)						

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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)
- ☐ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.)
- ☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)

Completed By: **Title:** **Date:** DD/MM/YYYY
Contact Number: **Direct Unit Phone Number:**

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