Hamilton Niagara Haldimand Brant (HNHB) LHIN

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

(Identify Referral Destination)

Patient's Last Name ______ First Name ______

Birthdate (yyyy/mm/dd) ______ Age ______

Rehabilitation Program Requested:

____

____

CCC Program Requested: ☐ Restorative ☐ Medically Complex ☐ Medically Complex – Ventilator ☐ Behavioural Health ☐ End of Life ☐ Medically Complex - Bariatric ☐ Medically Complex - Dialysis

Referral Date (yyyy/mm/dd) ______

Estimated Date of Rehab/CCC Readiness: (yyyy/mm/dd) ______

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: ______ (yyyy/mm/dd) Gender: ☐ M ☐ F ☐ Other______ Marital Status: ______

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ Other ______

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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Date (yyyy/mm/dd) ____________________

Patient's Last Name ____________ First Name ____________

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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 → (list) ______________________________

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF
☐ ESBL ☐ TB ☐ Other (Specify): ______________________________

Admission Date: ______________ (yyyy/mm/dd) Date of Injury/Event: ______________ (yyyy/mm/dd) Surgery Date: ______________ (yyyy/mm/dd)

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: __________ cm **Weight:** __________ kg

Is Patient Currently Receiving Dialysis: ☐ No ☐ Yes → ☐ Peritoneal ☐ Hemodialysis
Frequency/Days: ______________ Location: ______________

Is Patient Currently Receiving Chemotherapy: ☐ No ☐ Yes → Frequency: ______________
Duration: ______________ Location: ______________

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Medical Information - Continued

Is Patient Currently Receiving Radiation Therapy:

☐ No ☐ Yes → Frequency: ______________ Duration: ____________ Location: ______________

Concurrent Treatment Requirements Off-Site: ☐ No ☐ Yes 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: ☐ No ☐ Yes - 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

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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

Patient Continent?: ☐ Yes ☐ No -- If Yes, Skip to Next Section

Bladder Continent: ☐ Yes ☐ No → ☐ Occasionally Incontinent ☐ Incontinent

Bowel Continent: ☐ Yes ☐ No → ☐ Occasionally Incontinent ☐ 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	Epidural: ☐ Yes ☐ No
Medication Pump: ☐ 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: ______________________________________

____

Cognition

Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to assess *(if No/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

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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 ☐ Sundowning
☐ Exit-Seeking ☐ Resisting Care ☐ Other ______________________

☐ Restraints → (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

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 x 1 ☐ Assist x 2 ☐ Mechanical Lift

Ambulation: ☐ Independent ☐ Supervision ☐ Assist x 1 ☐ Assist x 2 ☐ Unable
Number of Metres: ________________

Weight Bearing Status: ☐ Full ☐ As Tolerated ☐ Partial ☐ Toe Touch ☐ Non

Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist x 1 ☐ Assist x 2

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Activities of Daily Living — Identify (✓) the Level of Function Prior to Hospital Admission (ADL & IADL) and the Expected Outcome

Activity	In-dependent		Cueing / Set-up or Supervision		Minimum Assist (1 person)		Moderate Assist (2 person)		Maximum Assist (Mech. Lift)		Total Care (Dependent)	
CS = Current Status EO = Expected Outcome	CS	EO	CS	EO	CS	EO	CS	EO	CS	EO	CS	EO
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)												

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:		

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Date (yyyy/mm/dd) ____________________

Attachments

Details on Other Relevant Information That Would Assist with this Referral:

____

____

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REQUIRED ATTACHMENTS FOR ALL REFERRALS

- ☐ Admission History and Physical
- ☐ Current Medication Administration Record

Relevant Assessments: ☐ Behavioural ☐ Physiotherapy ☐ Occupational Therapy ☐ Social Work ☐ Nursing ☐ Physician

All relevant Diagnostic Imaging Results: ☐ CT Scan ☐ MRI ☐ X-Ray ☐ Ultrasound ☐ Other ____________________

Relevant Consultation Reports:

☐ Physiotherapy ☐ Occupational Therapy ☐ Speech and Language Pathology

☐ Other Psychologist or Psychiatrist consult notes if behaviours are present ____________________

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REQUIRED ATTACHMENTS FOR SPECIFIC COMPLEX CONTINUING CARE (CCC) PATIENT STREAMS

- ☐ CCAC Behavioural Assessment for Behavioural Health Applications
- ☐ Cohen Mansfield Agitation Inventory (CMAI) for Behavioural Health Applications
- ☐ Victoria Hospice Society's Palliative Performance Scale (PPS) for End of Life Care Applications

Completed By: ____________________ (Printed Name) ____________________ (Signature & Designation) **Date:** ____________ (yyyy/mm/dd)

Contact Number: ____________________ **Direct Unit Phone Number:** ____________________