Fax to SPH Admissions: 905-549-4030
After hours/weekends Palliative Care only: 905-549-6829
WLMH Admissions: 905-945-2367

Complex Care & Rehabilitation Application Form

** Required Field*

Patient Name*________________ **HCN***__________ **VC***____ **DOB*** dd/mm/yyyy _ **Gender ***

Address*____________________ **City***__________ **Province***______ **Postal Code***__________

Patient Phone*____________ **Height***________ **Weight***________ **Hospital Admission Date** *dd/mm/yyyy

Primary Language* ☐ English ☐ French ☐ Other – specify__________ **Patient Speaks and Understands English *** ☐ Yes ☐ No

Interpreter Needed* ☐ Yes ☐No Specify______________ **Family Physician***______________

Emergency Contact Information

Primary Contact*________________ **Relationship***__________ **Phone***__________

Power of Attorney Personal Care______________________ **Phone**__________

Power of Attorney Financial Care______________________ **Phone**__________

Substitute Decision Maker______________________ **Phone**__________

Public Guardian & Trustee______________________ **Phone** __________

Referral Source

Hospital Site*____________ **Sending Unit***________ **Community Agency** ______________

Primary Contact for Bed Offer*______________________________

Phone*______________ **Fax***______________ **Cell Phone***______________

Application Stream and Choices

Complex Care/Rehab Stream*________________ **CC/LIR Bed Type***______________

High Intensity Rehab Bed Type*________________ **Readiness Date*** dd/mm/yyyy

☐ BCHS ☐ HDS ☐ HHS ☐ HHS–SPH ☐ HHS–WLMH ☐ HWMH ☐ JBH ☐ NGH ☐ NH-DMH ☐ NH-GNG ☐ NH–PCH ☐ NH–WHS ☐ SJHH

Isolation Status

Isolation Required? ☐ Yes ☐ No **ARO/Isolation Reason** ☐ MRSA ☐ VRE ☐ C-Diff ☐ Other–Specify______________

COVID-19 Status ☐ **Positive** ☐ **Negative** ☐ **Resolved** ______________

Discharge Plan (Destination and Care Plan)

☐ **Home** ☐ **Supervised or Assisted Living** ☐ **Retirement Home –specify** ______________________

☐ **Other – specify** ______________________________

Previous Community Supports? If yes, specify ______________________

Discharge Plan discussed with patient/family ☐ Yes ☐ No **Date dd/mm/yyyy** ______________

Information provided to________________ **Information provided by** ________________

Planned Discharge – Barriers & Challenges

Describe any known barriers or challenges to discharge (e.g. homelessness, family dynamics, home renovations, no support system.)

Patient Name____**HCN** ____________________________

Diagnosis / Medical History

Relevant Medical Diagnosis (reason for application) **Primary Diagnosis*** ________________________________

Relevant Co-Morbidities

Upcoming Appointments / Pending Investigations / Scheduled Tests and/or Procedures ☐ **More information in ClinicalConnect**

Type	Physician / Surgeon	Scheduled Date	Notes
		dd/mm/yyyy	
		dd/mm/yyyy	
		dd/mm/yyyy	
		dd/mm/yyyy	

☐ **Smoking** ☐ **Alcohol** ☐ **Non-Script Drugs -specify**____

Allergies* (Medication, Environmental, Food)_________________________________☐ **Document(s) Attached**

Advanced Directives ☐ Yes ☐ No If yes, specify_________________________________☐ **Document(s) Attached**

Palliative Performance Scale (PPS)_______ **Spiritual Needs** ________________________________

Mobility

Weight Bearing Status

Upper Extremity Left	**Date of Assessment** dd/mm/yyyy
Upper Extremity Right	**Date of Assessment** dd/mm/yyyy
Lower Extremity Left	**Date of Assessment** dd/mm/yyyy
Lower Extremity Right	**Date of Assessment** dd/mm/yyyy

Current Sitting Tolerance minimum 2-3 hrs./day ☐ Yes ☐ No ☐More than 2 Hours ☐ 1-2 Hours ☐ Less than 1 Hour Daily ☐ Has Not Been Up If No, explain ____

Potential Therapy Tolerance (More than 1 hour per day up to 7 days/week) ☐ Yes ☐ No

If No, explain ____

Bed Mobility (Movement Restrictions/Precautions)____

Neuro Rehab only - ☐ Alpha FIM Motor ________________ Cognitive ______________ Total __________

Participation Notes

☐ Special Equipment - specify ____

☐ Specialty Bed/Mattress (e.g. Bariatric, air mattress) – specify ________________________

☐ One Person Transfer

☐ Two Person Transfer

☐ Mechanical Lift

Patient Name____**HCN** _______________________________

Functional Status & Goals

1 = Total Assistance, 2 = Maximal Assistance, 3 = Moderate Assistance, 4 = Minimal Assistance, 5 = Supervision, 6 = Modified Independence, 7 = Complete Independence

	Premorbid Status	Current Status	Required Status to Achieve discharge plan (SMART GOALS / Compensatory Strategies)	Demonstrates Recent Progress	
				Y/N	Explain
Self Care					
Eating					
Grooming					
Bathing					
Dressing – Upper Body					
Dressing – Lower Body					
Toileting					
Sphincter Control					
Bladder Management					
Bowel Management					
Mobility/Transfer					
Bed– Chair – Wheelchair					
Toilet					
Tub –Shower					
Locomotion					
Walk-Wheelchair					
Stairs					
Communication					
Comprehension					
Expression					
Social Cognition					
Social Interaction					
Problem Solving					
Memory					

Cognition

Observed Behaviours (present or exhibited within the last 3 days)

☐ Verbally Responsive ☐ Physically Responsive ☐ Demonstrating Agitation ☐ Resisting Care ☐ Wandering ☐ Sun Downing

☐ Exit Seeking ☐ Bed Exiting ☐ Other ____

Restraints Required? ☐ Yes ☐ No **Restraint Type** ☐ Physical ☐ Chemical ☐ Environmental Specify__________________________

Behavioural Management Plan attached ☐ Yes ☐ No

Cognitive Assessment Score___________ **Assessment Tool Used**_______________________________**Depression Score**___________

Patient Name____**HCN** ______________________________

Medical Management

☐ Pain Management Strategy ☐ Yes ☐ No Pain Pump Type ______________

Pain Frequency____ Pain Intensity __________________________

☐ Tracheostomy Size__________Type__________☐ Suction – Type_____________☐ IV Therapy - Access Line ____________________

☐ Number of wounds & location____☐ Wound Reports Attached

☐ Drain(s) Details____________________________________☐ Negative Pressure Wound Therapy - Details __________________________

Ostomy/Colostomy ☐ Old ☐ New ☐ Revised ☐ N/A ☐ Ostomy Report Attached Level of Care_____________Catheter ☐ Yes ☐ No

☐ Feed Tube__________________Diet Type___________________Fluid Type ___________________

☐ Halo ☐ Orthosis ☐ Pleuracentesis ☐ Paracentesis

☐ Bi PAP ☐ CPAP (Patient must bring own machine) ☐ Oxygen Required ☐ RT Required

☐ Chemotherapy Frequency______________________☐ Radiation Frequency _____________________________

☐ Dialysis Schedule______________________________☐ Peritoneal Dialysis Schedule ______________________

Other

Relevant Attachments (please provide the following if not available to the receiving organizations electronically)

☐ Recent patient history and relevant assessments/consult notes

☐ Progress notes summarizing current medical conditions (within last 72 hours)

☐ Last relevant lab results

☐ Medication list (BPMH, MAR, medication record, discharge medication record)

Completed by* Signature* Date* dd/mm/yyyy

Patient or Substitute Decision Maker Consent*

The above information has been explained to me by________________________and I have had the opportunity to ask questions about the program and discharge process.

I understand that:

1. The above information will be shared for the purposes of a complex care and/or rehabilitation application
2. These programs are transitional in nature
3. I will transition out of hospital when my complex care/rehabilitation care needs are met or can no longer be met in hospital and a suitable alternate plan has been developed.

_______________________________ _______________________________ _________________

Printed Name of Patient or Substitute Decision Maker * Signature * Date * (dd/mm/yyyy)