Transfer of Rehabilitative Care

in the Mississauga Halton LHIN

ORGANIZATION INFORMATION

Referral Date: Date: mm/dd/yyyy

Sending Organization: Please click on dropdown arrow

Other:

1. **First Choice Receiving Organization:** Please click on the dropdown arrow

Primary Program Being Referred to: Hand Program Third (THP-Q Site)

Reason Why: (referral made to multiple programs) Please click on the dropdown arrow

2. **Second Choice Receiving Organization:** Please click on the dropdown arrow

Secondary Program Being Referred to: Please click on the Dropdown arrow

3. **Other:**

Program Being Referred to:

CLIENT DETAILS AND DEMOGRAPHICS

Client Information:

First and Last Name:

DOB: mm/dd/yyyy

Health Card # and Version Code: (Optional)

Address:

City and Province:

Country and Postal Code:

Telephone #:

Alternate Telephone #:

Languages Spoken:

Living Situation: Please click on dropdown arrow

Other:

Gender Please click on dropdown arrow

Other:

MANDATORY

Client consent obtained to share the information on this referral?

☐ Yes ☐ No

☐ Consent limitations, please specify below.

Does the client have a Primary Care doctor? If yes then list Primary Care Doctor name and number below.

☐ Yes ☐ No

First and Last Name:

Telephone #:

Caregiver Information:

Is the patient capable of making their own decision? ☐ Yes ☐ No If no then list substitute decision maker name and phone number below.

Relationship to client: Please click on arrow

Other:

First and Last Name:

Telephone #:

REHABILITATIVE CARE NEEDS

Diagnosis Specific to Referral:

Reason for referral / patient goals:

☐ PT

☐ OT

☐ SLP

☐ SW

☐ Dietitian

☐ Other

Please list any (pre) existing factors that would impact client participation in program (physical, social, financial etc.): ☐ N/A

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PATIENT ASSESSMENT– HEALTH SERVICE PROVIDER

Each provider to update this section based on client specific goals that their organization was responsible for.

Select Applicable Rehab Outcome Measure	Score	Date mm/dd/yyyy	N/A	Comments (optional)
Physiotherapy Specific:				
1. Berg Balance Scale			☐	
2. Timed Up & Go			☐	
3. Lower Extremity Functional Scale LEFS			☐	
4. Other:			☐	
Occupational Therapy Specific:				
1. MOCA			☐	
2. Mini Mental			☐	
3. Chedoke-McMaster Stroke Assessment (hand/arm)			☐	
4. Grip Strength			☐	
5. Other:			☐	
Speech Language Pathology Specific:				
1. ASHA NOMS FCM (comprehension/speech/problem solving/ reading/memory)			☐	
2. Dysphagia, (diet texture and instrumental assessment)			☐	
Dietitian:			☐	
Social Worker:			☐	

Frailty assessment scale completed on client? ☐ Yes Please click on dropdown arrow ☐ No

Equipment Needs

1. ADL equipment in place: ☐ N/A

2. Seating and/or ambulation aids: ☐ N/A

CURRENT FUNCTIONAL STATUS

Activity Tolerance: ☐ More than 2 hours daily ☐ 1-2 hours daily ☐ Less than 1 hour dailv ☐ Unknown ☐ Other

Transfers: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Mechanical Lift

Ambulation: ☐ Independent-No of meters ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Unable

☐ Gait aid used?

Weight Bearing Status: ☐ Full ☐ As tolerated ☐ Partial* ☐ Toe touch* ☐ Non*

Stairs: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Stair lift/glider

* If Partial, Toe, Touch, Non, selected please complete the following:

Duration: **Next Fracture Clinic Appointment:**

Date: mm/dd/yyyy

Ontario

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ACTIVITIES OF DAILY LIVING (please skip if this does not apply) ☐

Provide Current Status: the assessment, below, provides information on the patient's ability to perform daily tasks. (Subject=Patient)

Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist (Subject is able to do 75% or more)	Moderate Assist (Subject is able to do 50% or more)	Maximum Assist (Subject is able to do 25% or more)	Total Care (Subject = able to do < 25%)
Eating: (Ability to feed self)	☐	☐	☐	☐	☐	☐
Grooming: (Ability to self-groom)	☐	☐	☐	☐	☐	☐
Dressing: (Upper body)	☐	☐	☐	☐	☐	☐
Dressing: (Lower body)	☐	☐	☐	☐	☐	☐
Toileting: (Ability to self-toilet)	☐	☐	☐	☐	☐	☐
Bathing: (Ability to wash self)	☐	☐	☐	☐	☐	☐

TRANSPORTATION (please skip if this does not apply) ☐

1. How is the patient going to get to the referred program?

2. If transportation assistance is required, please identify transportation application/s completed.

COGNITION (please skip if this does not apply) ☐

History of Diagnosed Dementia: ☐ Yes ☐ No **If No or unable to assess, skip to next section**

Cognitive Impairment: ☐ Yes ☐ No

Has the Patient shown the ability to learn and retain information? ☐ Yes ☐ No

Recommended Strategies for Intervention:

History of responsive behaviours: ☐ Yes ☐ No **Status:** Please click on dropdown arrow

Delirium: ☐ Yes ☐ No

Has the Behavioural Supports Office Help Line been engaged? ☐ Yes ☐ No

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Attachments ☐
Please list attached documents. (discharge summary report, physio assessment report etc.)

Additional comments to support the referral:
(Nursing needs, willingness or motivation to participate in Rehab, other)

CONTACT INFORMATION OF REFERRING THERAPIST/TEAM

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** Please click on dropdown arrow

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** Please click on the dropdown arrow

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** Please click on the dropdown arrow

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** Please click on the dropdown arrow below

Referring Physician Name: _____ Referring Physician Signature: _____ Date: mm/dd/yyyy

Referring Team (optional): _____ Telephone#: _____ Date: mm/dd/yyyy **Sending Organization:** Please click on the dropdown arrow

Other: