Transfer of Rehabilitative Care

in the Mississauga Halton LHIN

ORGANIZATION INFORMATION

Referral Date: _____ (mm/dd/yyyy)

Sending Organization: _____

1. **First Choice Receiving Organization:** _____ **Primary Program Being Referred to:** _____
2. **Second Choice Receiving Organization:** _____ **Secondary Program Being Referred to:** _____
3. **Other:** _____ **Program Being Referred to:** _____

Reason Why: (referral made to multiple programs) _____

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 Province _____

Telephone #: _____ Alternate Telephone #: _____ Gender _____

Languages Spoken: _____ **Living Situation:** _____

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? ☐ Yes ☐ No

If yes then list Primary Care Doctor name and number below.

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: _____ 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's 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 _____ ☐ 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 daily ☐ 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

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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:** _____

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:** _____

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** _____

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** _____

First Name and Last Name: _____ Signature: _____ **Referring Clinician:** _____

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

Referring Team (optional): _____ Telephone#: _____ Date: mm/dd/yyyy _____ **Sending Organization:** _____