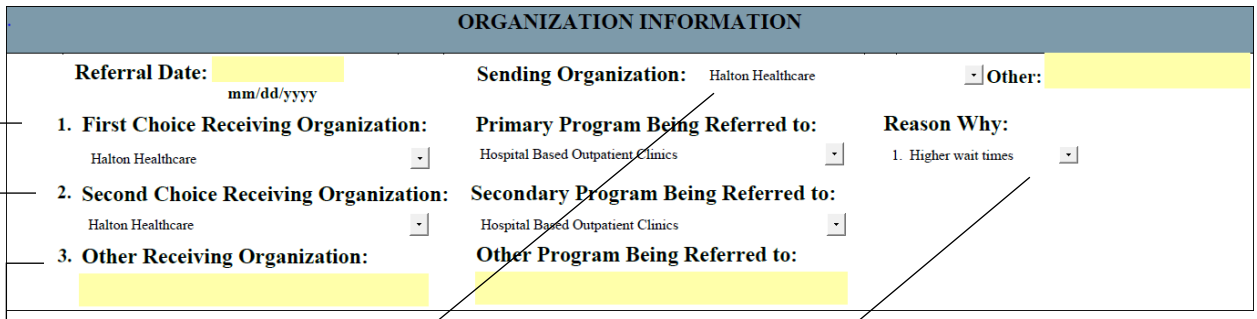
TRANSFER OR REHABILATATIVE CARE
FORM COMPLETION GUIDE

The following information is designed to help the users of the form understand what information is to be entered in each section when completing the form. It also notes mandatory versus optional fields for the data entry. Please ensure that you review this form completion guide so that you are aware of how to complete each section within the Transfer of Rehabilitative Care form prior to use. Unless otherwise stated (sections that can be skipped or optional) an attempt to complete all data fields must be made.



Referral Date: Enter the date of referral i.e. the day the referral is submitted to another rehab provider. Format: mm/dd/yyyy

Sending Organization: Click on drop down arrow and scroll through list to find the "Sending Organization".
Other: If the organization is not on the list, click on "other" from the drop down list and type the organization name in the text box located to the right of "Sending Organization" drop box.

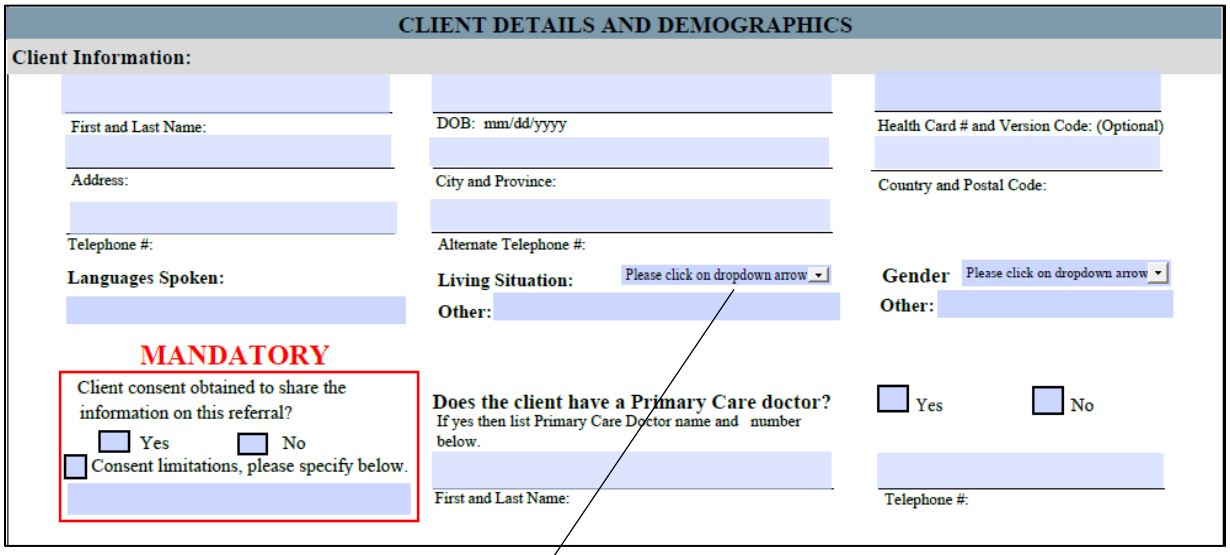
1. **First Choice Receiving Organization:** Click on the drop down box to select your first choice of receiving organization for the patient transfer of rehabilitative care
Primary Program Being Referred to: Some providers have more than one rehab program that they offer, please select from the drop down list which program at your first choice recceing organization are you making the referral to.

Reason Why: This drop down list is used when you are using the same referral for the same patient to go to be sent out to more than one receiving organization. The drop down list includes options for: higher wait times, patient choice, different rehab program, and location.

2. **Second Choice Receiving Organization:** Similar to your first choice for receiving organization, if you are sending the referral to more than one rehab program, please use this data field to select a rehab provider organization and associated program that you are making a referral to under **"secondary program being referred to"**

3. **Other Receiving Organization:** If you need to send a referral to a third rehab provider organization or to a rehab provider that is not listed in the drop down please use this data field to type in their name. Under "**Other Program Being Referred to"** please identify which program at this organization you are referring the patient to.

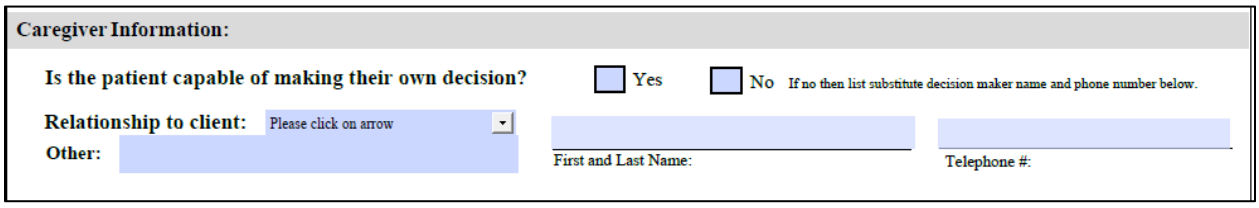
Please ensure that this top section (Organization Information) is completed accurately as it lets all receiving organizations know if the sender has made more than one referral for the same client and to which organizations. This information will help keep everyone in the loop around the various rehab supports required for the patient and the various rehab providers engaged for the delivery the therapy needed.



Please complete the client details and demographics section as indicated.

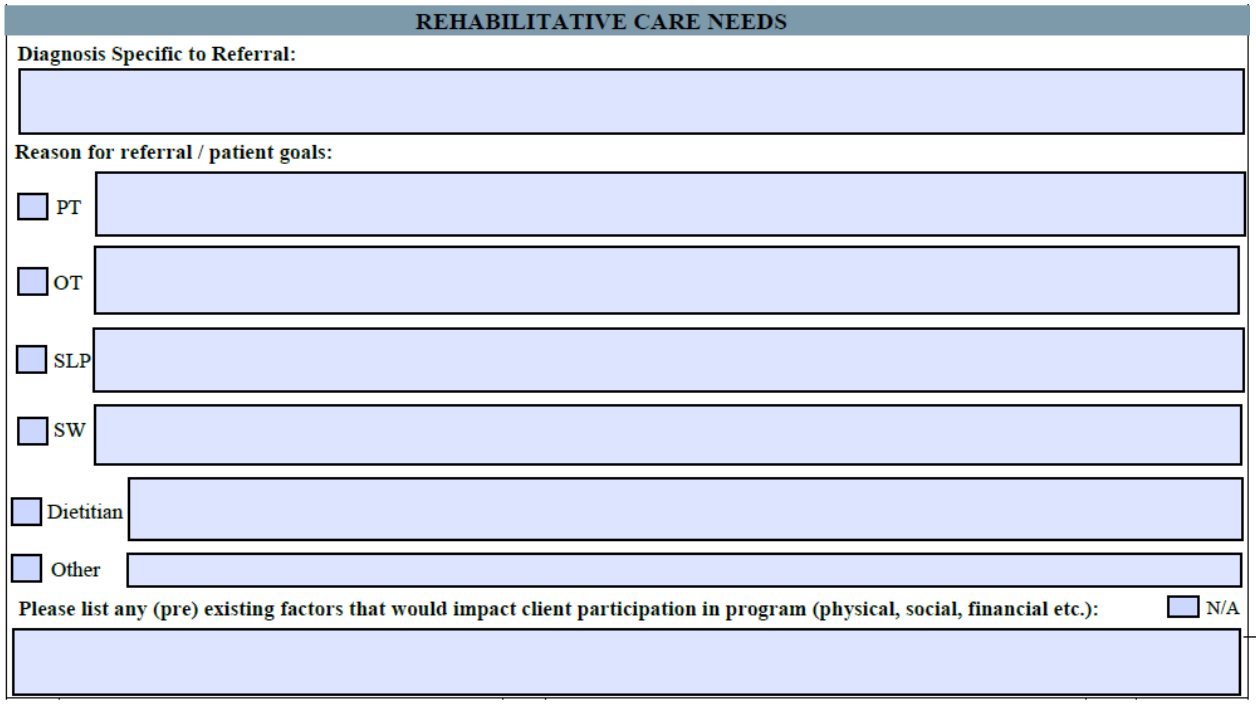
Please note it is very important that if a Transfer of Rehabilitative Care form is being completed that you seek patient consent prior to completing the form. The patient needs to provide permission that their information on the TRC form can be shared with another rehab provider. This consent is to be obtained every time a Transfer of Rehab Care form is completed so at any new transition point. If the patient has provided limited consent, so that information can be shared with select providers only, please ensure that this is accurately reflected in the red box section around client consent on the form. <u>This is mandatory</u>.

Living Situation: As indicated an attempt to complete all sections and data fields on the form should be made, this data field lets the receiving therapists know about the client's current living situation to address occupational therapy and other related supports.



The Caregiver section is an important section to complete for staff completing the TRC form. If the client has a caregiver their contact information should be noted in this section to be shared with the next

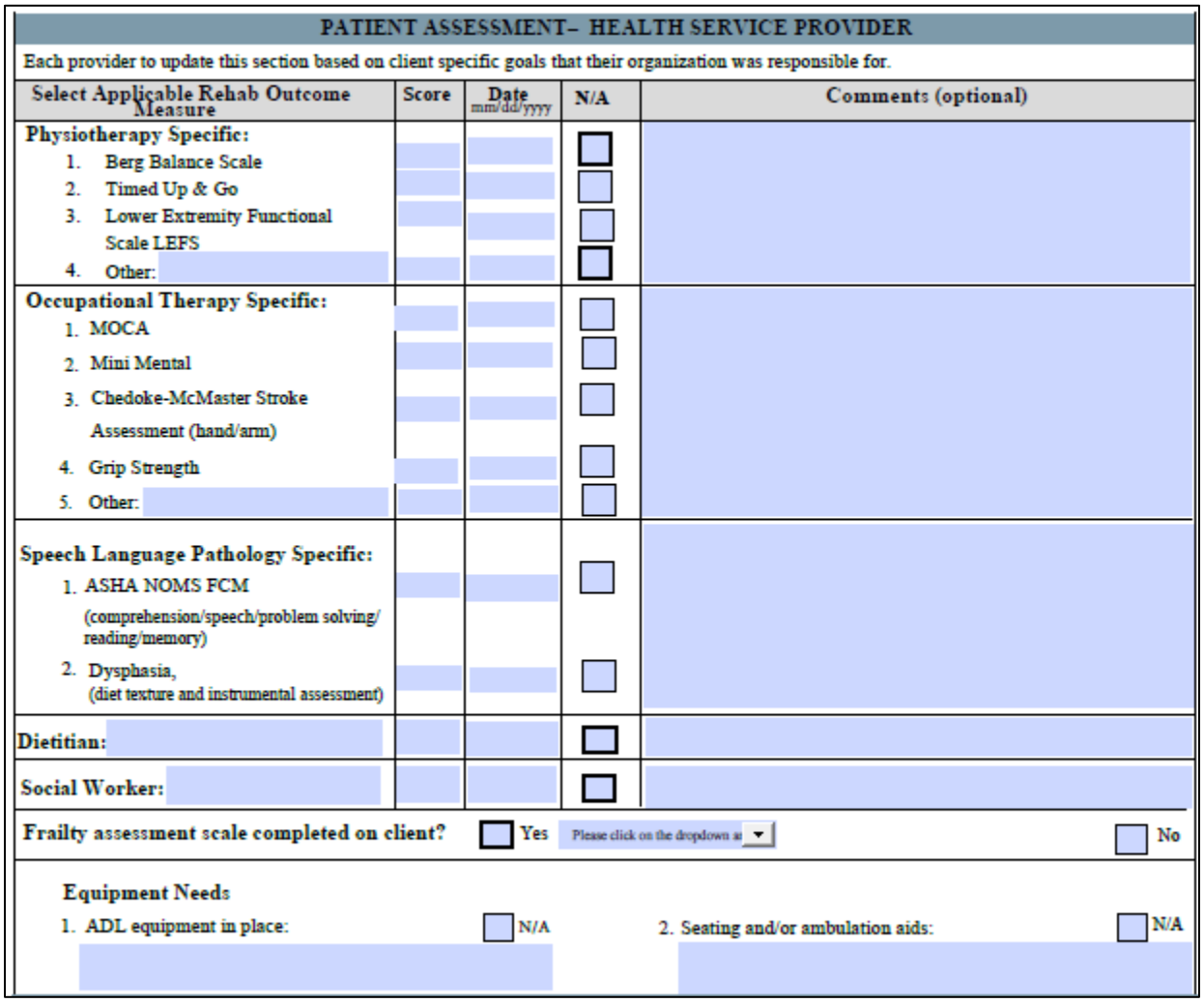
rehab provider. This helps the receiving organization make in expediting any decisions related to the patient treatment plan or care plan knowing who to contact and saves time.



Diagnosis Specific to Referral: Please identify the medical diagnosis pertaining to the referral being made. i.e. knee replacement surgery requires physiotherapy. Etc.

Reason for Referral/ Patient goals: In this section please clearly communicate what the expected rehab goals or outcomes for the patient are based on your assessment and why the referral is being made to the respective organization. This section has been expanded for allied staff to include allied specific goals for the patient. For example, referral to community step-up program post outpatient neuro stroke rehab at a hospital might indicate. “Additional rehab needed to improve mobility and communication, physiotherapy and speech therapy to manage daily tasks”, including OT, PT and SLP specific notes for patient goals.

Please list any (pre) existing factors that would impact client participation in program (physical, social, financial etc.): please identify any medical conditions/barriers to care could be social, financial for the patient impacting their potential to participate in the program. E.g. “early onset dementia, no caregiver support”.



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. Dysphasia, (diet texture and instrumental assessment)			☐	
Dietitian:			☐	
Social Worker:			☐	

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

Equipment Needs

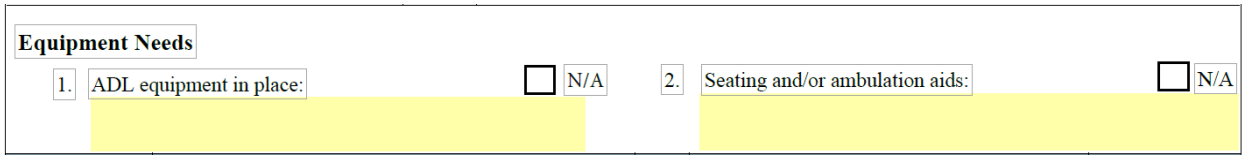
1. ADL equipment in place: ☐ N/A
2. Seating and/or ambulation aids: ☐ N/A

This is a very important section and acts as a main communication tool for therapists to share discipline specific outcome measures based on their assessment of the patient with the receiving therapist.

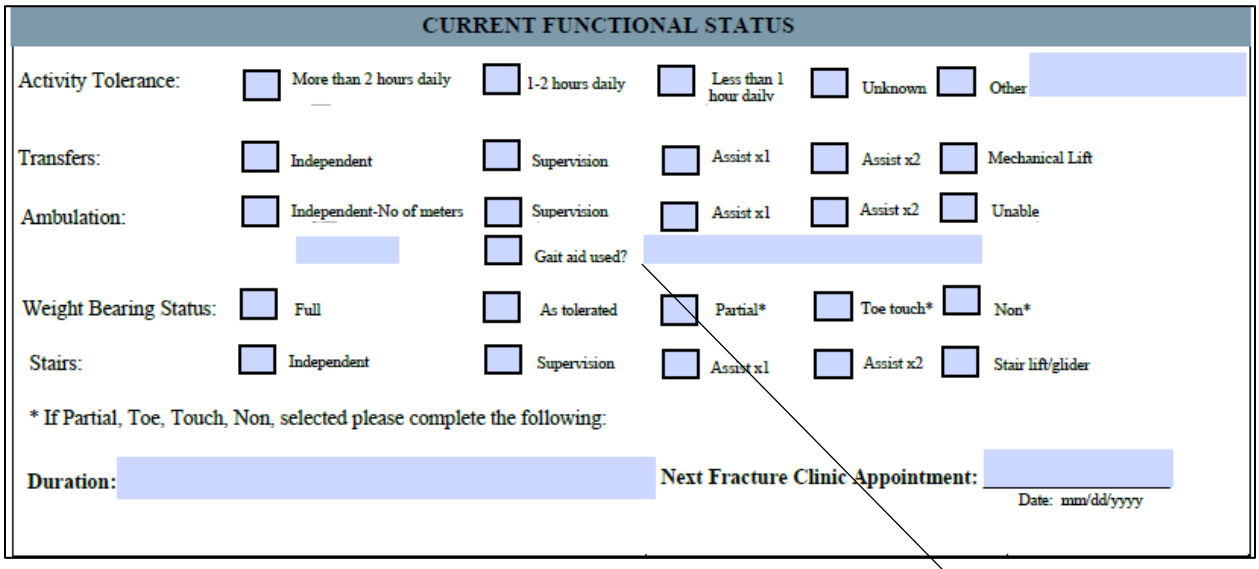
This section is broken down into five professional rehab services, Physiotherapy, Occupational therapy, Speech Language Pathology, Dietician, and Social Work. Based on the service/s received by the client the sending therapists are to complete their specific sections.

Each discipline section has a set of specified or commonly used outcome measures indicated under the discipline. Please select the most appropriate measures used for patient assessment. You will note that there is an “Other” field under the outcome measures section to capture any outcome measures not listed here but used by the therapist. The columns next to the outcome measures ask for a final score of the outcome measure used, the date the particular tool was used to assess the patient, a section that states Not Applicable (N/A, please select if the measures do not apply to the patient being referred) and an optional comments section, allowing the sending therapist to communicate any information with the receiving therapist regarding their patient assessment.

Frailty assessment Scale completed on client: The clinical frailty scale is used as a common tool for the frail and senior population to assess their frailty and supports needed. We have included a copy of this frailty scale towards the end of this guide under Appendix A. Please use the drop down to select the level of frailty specific to the patient being referred. Note this might not apply to all patients being referred based on their age, please check the box that says "No", if the frailty assessment is not completed. Proper training and education should be provided around the use of this tool with clarity around roles and responsibilities for who will be completing the "Frailty Assessment Scale" on the client.



This brief section is to be completed by sending therapists to identify 1) any specific **equipment needs** for the patient, select N/A if this does not apply to your patient. **2) Seating and ambulation aids:** please list any seating or ambulation aids needed for the patient or select N/A if this does not apply.



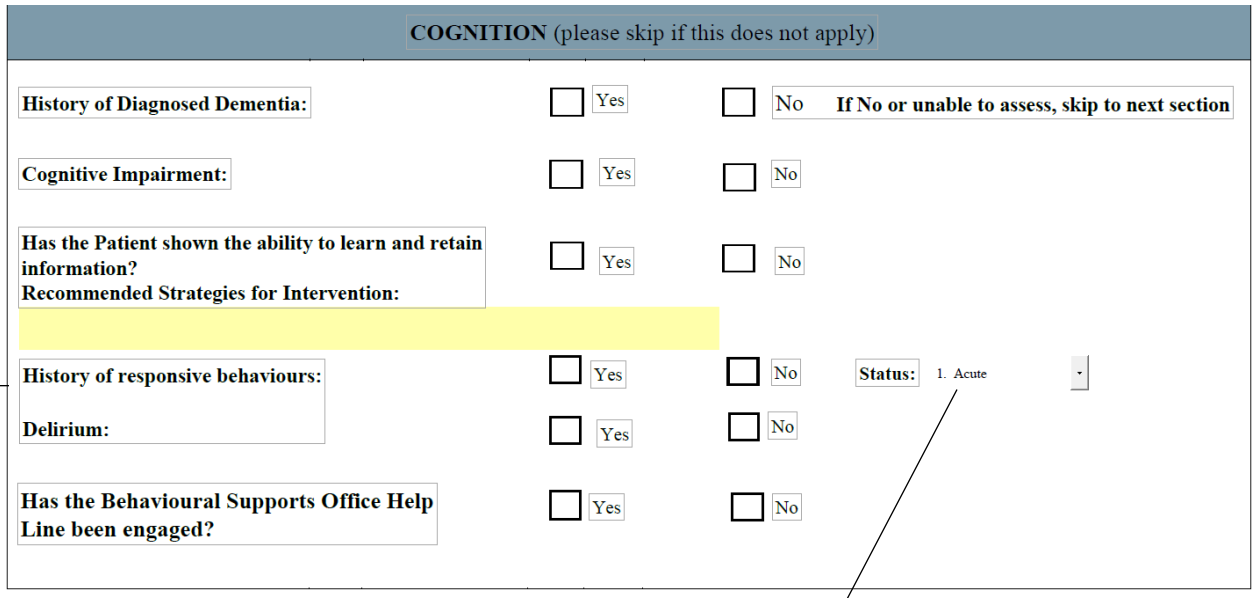
Please complete this section for your patient by simply checking all boxes that apply under sitting tolerance, Transfers, Ambulation, Weight Bearing Status, and Stairs. Please note any gait aid used would be reflected here under ambulation.

ACTIVITIES OF DAILY LIVING (please skip if this does not apply)						
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 self-groom)	☐	☐	☐	☐	☐	☐
Dressing: (Upper body)	☐	☐	☐	☐	☐	☐
Dressing: (Lower body)	☐	☐	☐	☐	☐	☐
Toileting: (Ability to self-toilet)	☐	☐	☐	☐	☐	☐
Bathing: (Ability to wash self)	☐	☐	☐	☐	☐	☐

Use the Activities of Daily Living section to provide additional information about the patient in terms of their functional assessment. Please check all boxes that apply. Please note this is an optional section and might not be required for all rehab transfers.

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.

Transportation is an important section to complete for the TRC form as it identifies any barriers to care specific to the patient's mobility or access to mobility affecting their participation in the receiving rehab program. Any information shared here specific to use of public transport or private mode of travelling will help the receiving therapist plan ahead and save time.



Based on the Rehabilitative Care Alliance of Ontario's best practice guidelines questions around cognition should be asked, cognitive impairment should not impact an individual's participation in rehab. However, an early assessment and communication of that assessment allows for appropriate rehab interventions to be planned and used for this patient population. This section allows for a cohesive cognitive assessment of the patient by the sending therapist to help address any dementia or cognitive impairment along with behaviours. This section might not be applicable to all patients so please skip if it does not apply.

History of responsive behaviours: please select "Yes" or "No" and select a status from the drop down. There are two options under the drop down 1. Acute, 2. Managing well. If assessed please select the appropriate response.

Has the behavioural supports Office helpline been engaged? Please select "Yes" or "No" to identify in case of responsive behaviours if the Behavioural Supports Office for Mississauga and Halton has been engaged.

Transfer of Rehabilitative Care
in the Mississauga Halton LHIN

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)

This section was included to allow for the ability to copy and paste information from hospital discharge reports and therapist summary reports. Any comments from other systems like meditech can be copied and pasted into the "Additional comments to support the referral" section. Along with any other information that the sending therapists would like to share that was not already provided through the TRC form including nursing needs/willingness or motivation to participate in rehab etc.

Please check box if you are attaching any documents with the TRC form so that the receiver know to look for them.

CONTACT INFORMATION OF REFERRING THERAPIST/TEAM

First Name: Last Name: Telephone #: **Referring Clinician:** Please click on dropdown arrow

Referring Team:

Signature: Date: mm/dd/yyyy **Sending Organization:** Please click on dropdown arrow

Other:

This is the last section of the TRC form. The sending therapist/team must provide their contact details in this section and state their role i.e. occupational therapist, Physiotherapist etc. Select your organization from the drop down menu. The text below is to list an organization that is not presented under the drop down menu list.

APPENDIX A: CLINICAL FRAILTY SCALE

Very Fit – Individuals who are robust, active, energetic, and motivated. These people commonly exercise regularly. They are among the fittest for their age
Well – Individuals who have no active disease symptom but are less fit than the very fit person. Often these people exercise or are very active occasionally e.g. seasonally

Managing Well – Individuals whose medical problems are well controlled, but are not regularly active beyond routine walking

Vulnerable – Individuals who are not dependent on others for daily help, often have symptoms that limit activities. A common complaint is being "slowed up", and/or being tired during the day

Mildly Frail – Individuals who often have more evident slowing and need help in high order IADLs' (finances, transportation , heavy housework, medications), typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework

Moderately Frail – Individuals who need help with all outside activities and with keeping house. Inside, they will often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing
Severely Frail – Individuals who are completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within 6 months)
**Adapted from the Queensland Stay on your Feet ® and Dalhousie University Clinical Frailty Scale*