North East Rehabilitation/Complex Continuing Care (CCC)
Cluster 3 Referral Form - Introduction

This form is designed to be filled out electronically, then printed and faxed to the facility you have chosen.

However, the option of printing out the blank form and filing it out by hand does exist. If when filling the form out by hand you determine that there is not enough room on the form for you to elaborate, please include your further information on another sheet of paper at the end of the referral form.

Note: If you are including additional pages to this form, remember to include the surname, first name and date of birth (D.O.B) up in the top right hand corner and number the pages to show the total number of pages to be received in the package.

Rehabilitation Criteria (all boxes must be checked to proceed with the application)

☐ The patient must have a physical impairment requiring rehabilitation **OR** have a known cognitive impairment requiring ongoing rehabilitation support or services.

☐ The patient is medically stable:

- A clear diagnosis and co-morbidities have been established.
- At the time of discharge from acute care, acute medical issues have been addressed: disease processes and/or impairments are not precluding participation in rehabilitation program.
- Patient's vital signs are stable.
- No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).
- Medication needs have been determined.

☐ The patient or a substitute decision-maker must willingly consent to participate in a rehabilitation program.

☐ The patient must have the cognitive ability to participate in and benefit from a rehabilitation program.

☐ The patient or a substitute decision-maker and medical team have identified realistic, specific, measureable and timely, functional goals for the rehabilitation process.

Complex Continuing Care Criteria (CCC)

- Please contact the Hospital with Complex Continuing Care beds within your HUB to discuss your patient's care requirements and they will assist you in determining the most appropriate placement. You will find contact information on the last page of this package.

REHAB/CCC REFERRAL

NE Rehab & CCC

Cluster 3 Acute Care to Rehab & Complex Continuing Care (CCC) Referral

Surname:	First Name:
CHRIS #:	Date of Birth (DD/MM/YYYY):
HCN:	Version Code

Identify Referral Destination: ☐ *Referral to Rehab*

☐ *Referral to Complex Continuing Care (CCC)*

If Faxed Include Number of Pages (Including Cover):

Estimated Date of Rehab/CCC Readiness (DD/MM/YYYY):

Patient Details and Demographics

Health Card #:	Version Code:	No Health Card #: ☐	No Version: ☐
Province Issuing Health Card: Select		Code: ☐	
Surname:		Given Name(s):	
No Known Address: ☐			
Home Address:		City:	Province: Select
Postal Code:	Telephone #:		Cell #:
Country:		No Alternate Telephone #: ☐	
Current Place of Residence (Complete If Different From Home Address):			
Date of Birth (DD/MM/YYYY):	Gender: ☐ M ☐ F ☐ Other:		Marital Status: Select
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 #:	Cell #:	No Alternate Telephone #: ☐	
Secondary Alternate Contact Person:		None Provided: ☐	
Relationship to Patient(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other _____			
Telephone #:	Cell #:	No Alternate Telephone #:☐	
Insurance Company:		N/A: ☐	
Current Location Name (referring source):			
City:			
Current Location Address:			
Province: Select	Postal Code:		
Current Location Contact Number:		Bed Offer Contact Number:	
Bed Offer Contact (Name):			

Completed By (Name):

Date (DD/MM/YYYY):

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Medical Information

Primary Health Care Provider (e.g. MD or NP)

Surname: | Given Name(s):

☐ Do Not Have A Primary Health Care Provider

Reason for Referral:

Allergies:	If Yes, List Allergies:
☐ No Known Allergies	
☐ Yes I have Allergies	

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

Admission Date DD/MM/YYYY: | Date of Injury/Event DD/MM/YYYY: | Surgery Date DD/MM/YYYY:

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: ☐ Inches ☐ cm | Weight: ☐ Pounds ☐ Kg

Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____

Location: _____

Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No Frequency: _____ Duration:_____

Location: _____

Completed By (Name): | Date (DD/MM/YYYY):

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Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No Frequency: _____ Duration:_____

Location:_____

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

Frequency of Lab Tests: _____ ☐ Unknown ☐ None

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements?: ☐ Yes ☐ No -- If No, Skip to the 'IV Therapy' 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 the 'Swallowing and Nutrition' 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

Please Include Any Special Diet Concerns:

Completed By (Name): Date (DD/MM/YYYY):

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Skin Condition

Surgical Wounds and/or Other Wounds Ulcers: ☐ Yes ☐ No -- If No, Skip to the 'Continence' 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*** ***(located at the end of this form).***

Continence

Is Patient Continent?: ☐ Yes ☐ No -- If Yes, Skip to the 'Pain Care Requirements' Section

Bladder Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Pain Care Requirements

Does the Patient Have a Pain Management Strategy?: ☐ Yes ☐ No -- If No, Skip to the 'Communication' Section

Controlled With Oral Analgesics: ☐ Yes ☐ No

Medication Pump: ☐ Yes ☐ No

Epidural: ☐ 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 the 'Cognition' Section

Communication Impairment Description:

Completed By (Name):

Date (DD/MM/YYYY):

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Cognition

Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess -- If No, or Unable to Assess, Skip to the 'Behaviour' 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

Behaviour

Are There Behavioural Issues: ☐ Yes ☐ No -- If No, Skip to the 'Social History' Section

Does the Patient Have a Behaviour Management Strategy?: ☐ Yes ☐ No

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering

☐ Sun downing ☐ Exit-Seeking ☐ Resisting Care ☐ Other

☐ Restraints -- If Yes, 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

Completed By (Name):	Date (DD/MM/YYYY):

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Current Functional Status

Sitting Tolerance:	☐ More Than 2 Hours Daily	☐ 1-2 Hours Daily	☐ Less Than 1 Hour Daily		☐ Has not Been Up
Transfer:	☐ Independent	☐ Supervision	☐ Assist x1	☐ Assist x2	☐ Mechanical Lift
Ambulation:	☐ Independent	☐ Supervision	☐ Assist x1	☐ Assist x2	☐ Unable
Number of Metres: _____					
Weight Bearing Status:	☐ Full	☐ As Tolerated	☐ Partial	☐ Toe Touch	☐ Non
Bed Mobility:	☐ Independent	☐ Supervision	☐ Assist x1	☐ Assist x2	

Activities of Daily Living

Level of Function Prior to Hospital Admission (ADL & IADL) :

Current Status – Complete the Table Below By Selecting One (1) Item Per Row:

Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
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)	☐	☐	☐	☐	☐	☐

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Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No -- If No, Skip to 'Rehab Specific AlphaFim® Instrument 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 'Attachments' 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:				

Attachments

Details on Other Relevant Information That Would Assist With This Referral:

Please Include With This Referral:

- ☐ Admission History and Physical
- ☐ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician)
- ☐ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.)
- ☐ Relevant Consultation Reports (e.g., Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)

Signature/Designation/Date (YYYY/MM/DD):

Print Name	Signature/Designation	Date (DD/MM/YYYY)

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

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North East Rehabilitation/Complex Continuing Care (CCC) Cluster 3 Referral Form – Contact Page

Contacts: (as appropriate)

Name	Designation	Phone #/Extension
	PT	
	OT	
	SW	
	SLP	
	RD	
	Nursing	
	Other:	

Have you applied to another Rehabilitation Centre? ○ No ○ Yes

If yes, please specify and provide date(s) applied: _____

Fax completed referral form and supporting documentation to your selected facility below if requesting <u>Rehabilitation</u>:

- **Health Sciences North**
  Clinical Manager, Intensive Rehab Unit
  Fax (705) 523-7091
- **Sault Area Hospital**
  Patient Care Manager, Rehabilitation Unit (2B)
  Fax (705) 256-3465
- **Timmins and District Hospital**
  Social Work/Discharge Planning,
  Rehabilitation/Complex Continuing Care/Interim LTC
  Fax (705) 267-6301
- **North Bay Regional Health Centre**
  Inpatient Rehab/ISU Clerk
  Phone (705) 474-8600 Extension 4680
  Fax (705) 495-7588
- **West Parry Sound Health Centre** Discharge Planner
  Fax (705) 773-4054

Please contact the Hospital with Complex Continuing Care beds within your HUB to discuss your patient's care requirements and they will assist you in determining the most appropriate placement.

- **St. Joseph's Continuing Care Centre Sudbury**
  Admissions Coordinator
  Phone (705) 674-2846 Extension 2112
  Fax (705) 674-9550
- **Sault Area Hospital**
  Patient Care Manager, CCC
  Phone (705)759-3434 Extension 4261
  Fax (705) 256-3458
- **Timmins and District Hospital CCC**
  Unit Manager
  Phone (705) 360-6066
  Fax (705) 267-6308
- **North Bay Regional Health Centre**
  Inpatient Rehab/ISU Clerk
  Phone (705) 474-8600 Extension 4680
  Fax (705) 495-7588