

Please use this fax cover sheet together with the GTA Rehab Network Referral Form.

- Be sure to fill in your sender Name, Phone, and Fax Number below.
- Please note, only fully completed referrals will be reviewed by the Patient Flow team. Please ensure you have included the following with your referral:
 - Physician/NP Signature
 - Copies of consultations
 - Copies of diagnostics
 - Diagnosis and reason for the inpatient rehabilitation referral

Fax

Date:

To: Admitting Office, Providence Healthcare

From:

Fax: 416-285-3759

Fax:

Phone: 416-285-3744

Phone:

Re: Referral to Inpatient Rehabilitation

Pages **(incl. cover)**:

Please see the attached referral to Inpatient Rehabilitation.

- Check one:
- Neurological (NOT including stroke rehab – Use E-Stroke Referral Form)
 - Orthopedic & Amputee
 - Geriatric & Medical
 - COVID-19

If you experience problems receiving this fax, please call the sender.

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Insert Health Service Provider Logo	Patient Identification	
Referral Destination		
IDENTIFY REFERRAL DESTINATION: <u>Bedded Level of Rehabilitative Care</u> <input type="checkbox"/> Rehabilitation – High Intensity <input type="checkbox"/> Complex Medical Management- Short Term <input type="checkbox"/> Rehabilitation – Low Intensity <input type="checkbox"/> Complex Medical Management- Long Term <input type="checkbox"/> Activation/Restoration – Hospital based/Other <input type="checkbox"/> Activation/Restoration – Convalescent Care (<u>REFER THROUGH HOME & COMMUNITY CARE</u>)	<u>Complex Continuing Care (CCC)</u> <input type="checkbox"/> Other programs (specify): _____ If Faxed Include Number of Pages (Including Cover): _____ Pages	
Estimated Date of Rehabilitative Care/CCC Readiness: DD/MM/YYYY		
Patient Details and Demographics		
Health Card #: _____ No Health Card #: <input type="checkbox"/>	Version Code: _____ No Version Code: <input type="checkbox"/>	Province Issuing Health Card: _____
Surname: _____		Given Name(s): _____
No Known Address: <input type="checkbox"/>		
Home Address: _____	City: _____	Province: _____
Postal Code: _____	Country: _____	Telephone: _____
Alternate Telephone: _____ No Alternate Telephone: <input type="checkbox"/>		
Current Place of Residence (Complete If Different From Home Address): _____		
Date of Birth: DD/MM/YYYY	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	Marital Status: _____
Patient Speaks/Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other _____		
Primary Alternate Contact Person:		
Relationship to Patient (Please Check All Applicable Boxes): <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____		
Telephone: _____	Alternate Telephone: _____	No Alternate Telephone: <input type="checkbox"/>

Insert Health Service Provider Logo	Patient Identification	
Secondary Alternate Contact Person: _____ None Provided: <input type="checkbox"/>		
Relationship to Patient: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ (Please Check All Applicable Boxes)		
Telephone: _____	Alternate Telephone: _____	No Alternate Telephone: <input type="checkbox"/>
Responsibility for Payment:		
Insurance: _____		N/A: <input type="checkbox"/>
<input type="checkbox"/> OHIP	<input type="checkbox"/> Federal Government	<input type="checkbox"/> IFH (Interim Federal Health Grant)
<input type="checkbox"/> Inter-provincial Insurance Plan	<input type="checkbox"/> Insured/Self Pay	<input type="checkbox"/> Other Payment Sources
<input type="checkbox"/> WSIB	<input type="checkbox"/> Uninsured/Self Pay	<input type="checkbox"/> Unknown
Preferred accommodation:		
<input type="checkbox"/> Ward	<input type="checkbox"/> Semi private	<input type="checkbox"/> Private
<input type="checkbox"/> Other (specify): _____		
For CCC Only - Co-Payment Discussed With: <input type="checkbox"/> Patient <input type="checkbox"/> Other _____		
Rehabilitative Care/CCC Population Requested:		
<input type="checkbox"/> ABI	<input type="checkbox"/> Amputee	<input type="checkbox"/> Burns
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Chronic Ventilation	<input type="checkbox"/> General/Medical
<input type="checkbox"/> Geriatric	<input type="checkbox"/> MSK	<input type="checkbox"/> Neuro
<input type="checkbox"/> Oncology	<input type="checkbox"/> Respiratory Rehab	<input type="checkbox"/> Spinal Cord
<input type="checkbox"/> Stroke	<input type="checkbox"/> Trauma	<input type="checkbox"/> Transplant
<input type="checkbox"/> Other _____		
Current Location Name: _____		Current Location Address: _____
City: _____	Province: _____	Postal Code: _____
Current Location Contact Number: _____	Bed Offer Contact Name: _____	Bed Offer Contact Number: _____
Medical Information		
Primary Health Care Provider (e.g. MD or NP) <input type="checkbox"/> None		
Surname: _____	Given Name(s): _____	
Allergies: <input type="checkbox"/> No Known Allergies <input type="checkbox"/> Yes --- If Yes, List Allergies: _____		
Infection Control: <input type="checkbox"/> None		
<input type="checkbox"/> MRSA	<input type="checkbox"/> VRE	<input type="checkbox"/> CDIFF
<input type="checkbox"/> ESBL	<input type="checkbox"/> TB	<input type="checkbox"/> COVID-19 (Specify details on next page)
<input type="checkbox"/> Other (Specify) _____		

<i>Insert Health Service Provider Logo</i>		Patient Identification	
COVID-19: Date of symptom onset/diagnosis: _____ DD/MM/YYYY List of symptoms:		1st Test: _____ 1 st Test Result: _____ DD/MM/YYYY	
		2nd Test: _____ 2 nd Test Result: _____ DD/MM/YYYY	
Admission Date: DD/MM/YYYY		Date of Injury/Event: DD/MM/YYYY	
Surgery Date: DD/MM/YYYY			
Nature/Type of Injury/Event:			
Primary Diagnosis:			
Current Medical Issues:			
Past Medical History:			
Attach the following:			
Medication: <input type="checkbox"/> MAR			
Lab Work: <input type="checkbox"/> If indicated, send most recent lab work (e.g. Haemoglobin, white blood cell count, lytes, creatinine)			
Height: _____		Weight: _____	
Is Patient Currently Receiving Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis Frequency/Days: _____			
Location: _____			
If Dialysis Centre is located off-site from rehab/CCC, indicate how patient will access Dialysis Centre:			
<input type="checkbox"/> Family drives <input type="checkbox"/> Volunteer drives <input type="checkbox"/> Wheel-Trans <input type="checkbox"/> Other _____			
Is Patient Currently Receiving Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____ Duration: _____			
Location: _____			

<i>Insert Health Service Provider Logo</i>	<i>Patient Identification</i>
Is Patient Currently Receiving Radiation Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____ Duration: _____ Location: _____	
Concurrent Treatment Requirements Off-Site: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Prognosis: <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Palliative Palliative Performance Scale: _____ <input type="checkbox"/> Unknown	
Advanced Medical Directives: _____	
Services Consulted: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SW <input type="checkbox"/> Speech and Language Pathology <input type="checkbox"/> Nutrition <input type="checkbox"/> Other _____	
Pending Investigations: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Frequency of Lab Tests: _____ Unknown: <input type="checkbox"/> None: <input type="checkbox"/>	
Study Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	
Respiratory Care Requirements	
Does the Patient Have Respiratory Care Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	
Was the patient intubated as part of their care?" <input type="checkbox"/> Yes Number of days _____ <input type="checkbox"/> No	
Supplemental Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No Ventilator: <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Target O2 Sat _____ % <input type="checkbox"/> Intermittent Oxygen _____ L/min <input type="checkbox"/> Constant Oxygen _____ L/min	
<input type="checkbox"/> O2 at rest _____ L/min <input type="checkbox"/> O2 at exercise _____ L/min	
Special Oxygen Equipment/Human Resources required? (e.g. rebreather, Optiflow, specialized resources of Respiratory Therapist): <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please specify): _____	
Breath Stacking: <input type="checkbox"/> Yes <input type="checkbox"/> No Insufflation/Exsufflation: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cuffed <input type="checkbox"/> Cuffless Type: _____ Size: _____	
Suctioning: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____	
C-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> No	

<i>Insert Health Service Provider Logo</i>	<i>Patient Identification</i>
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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 Next Section

IV Therapy: Yes No Central Line: Yes No PICC Line : Yes No

Name of IV Medication:

Hearing/Vision

Hearing:

Intact, can hear routine conversation Intact, with hearing aid Reduced hearing Completely impaired

American Sign Language

Vision:

Intact Intact with visual aid Visual field deficit Double vision Completely impaired

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 Tube Type: _____ Specify Formula Type & Rate of Feeds: _____

Therapeutic Diet Type: Regular Kosher Diabetic Renal Low Sodium Other (specify): _____

Diet Texture: Regular Other (specify): _____

Falls

Does Patient Have a History of Falls? Yes No -- If No, Skip to Next Section

Insert Health Service Provider Logo	Patient Identification
If yes, specify: <input type="checkbox"/> home/community <input type="checkbox"/> hospital History & Frequency: <input type="checkbox"/> Frequent <input type="checkbox"/> Rare <input type="checkbox"/> Intermittent	
Reason for most recent fall(s): <input type="checkbox"/> Balance <input type="checkbox"/> Vision <input type="checkbox"/> Strength <input type="checkbox"/> Fatigue <input type="checkbox"/> Decreased insight/judgment <input type="checkbox"/> Unknown <input type="checkbox"/> Other (list):	
Skin Condition	
Surgical Wounds and/or Other Wounds Ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section	
1. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
2. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
3. Location:	Stage:
Dressing Type: (e.g. Negative Pressure Wound Therapy or VAC)	Frequency:
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes	
* If additional wounds exist, add supplementary information on a separate sheet of paper.	
Continence	
Is Patient Continent? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If Yes, Skip to Next Section	
Bladder Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent
Bowel Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent
Ostomy: <input type="checkbox"/> N/A <input type="checkbox"/> Yes Type/brand and care/products required _____	
Ability to care for ostomy: <input type="checkbox"/> Independent <input type="checkbox"/> Total care <input type="checkbox"/> Requires supervision	

<i>Insert Health Service Provider Logo</i>	<i>Patient Identification</i>		
Pain Care Requirements			
Does the Patient Have a Pain Management Strategy? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section			
Controlled With Oral Analgesics:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Medication Pump:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Methadone:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Epidural:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has a Pain Plan of Care Been Started? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Communication			
Does the Patient Have a Communication Impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section			
Communication Impairment Description:			
Cognition			
Cognitive Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Assess -- If No or Unable to Assess, Skip to Next Section			
Details on Cognitive Deficits:			
Has the Patient Shown the Ability to Learn and Retain Information: <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Details: _____			

Cognitive Status (Complete Table Below)	Not Tested	Intact	Impaired
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Able to follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Memory (short term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):

Insert Health Service Provider Logo		Patient Identification	
Memory (long term)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Frustration Tolerance (ABI only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify):
<input type="checkbox"/> MMSE Score: _____ or <input type="checkbox"/> MoCA Score: _____	<input type="checkbox"/>	If did not/unable to complete, please explain:	
Rancho Los Amigos Cognitive Scale at present: (ABI only): _____			
Delirium: <input type="checkbox"/> Yes <input type="checkbox"/> No -- If Yes, Cause/Details: _____			
History of Diagnosed Dementia: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Behaviour			
Are There Behavioural Issues? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section			
Does the Patient Have a Behaviour Management Strategy: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Behaviour: <input type="checkbox"/> Need for Constant Observation <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Agitation <input type="checkbox"/> Wandering <input type="checkbox"/> Sundowning <input type="checkbox"/> Exit-Seeking <input type="checkbox"/> Resisting Care <input type="checkbox"/> Other <input type="checkbox"/> Restraints -- If Yes, Type/Frequency Details : _____			
Level of Security: <input type="checkbox"/> Non-Secure Unit <input type="checkbox"/> Secure Unit <input type="checkbox"/> Wander Guard <input type="checkbox"/> One-to-one			
Social History			
Discharge Destination: <input type="checkbox"/> Multi-Storey <input type="checkbox"/> Bungalow <input type="checkbox"/> Apartment <input type="checkbox"/> LTC <input type="checkbox"/> Retirement Home (Name):			
Accommodation Barriers:			<input type="checkbox"/> Unknown
Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No Details:			
Alcohol and/or Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Details:			

<i>Insert Health Service Provider Logo</i>	<i>Patient Identification</i>
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Limbs:

Left: U/E impairment L/E impairment Aid(s) Required: _____

Right: U/E impairment L/E impairment Aid(s) Required: _____

Bed Mobility: Independent Supervision Assist x1 Assist x2

Activities of Daily Living

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

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 wash face/hands, comb hair, brush teeth)						
Dressing: (Upper body)						
Dressing: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						

<i>Insert Health Service Provider Logo</i>	<i>Patient Identification</i>		
Special Equipment Needs			
Special Equipment Required? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section			
<input type="checkbox"/> HALO <input type="checkbox"/> Orthosis (including splints, slings) <input type="checkbox"/> Bariatric - If Yes, Please Describe Equipment Needs: _____ <input type="checkbox"/> Other:			
Pleuracentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, Type Details: _____			
Paracentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, Type Details: _____			
Need for a Specialized Mattress: <input type="checkbox"/> Yes <input type="checkbox"/> No Negative Pressure Wound Therapy (NPWT): <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Rehabilitative Care Specific</i> AlphaFIM® Instrument			
Is AlphaFIM® Data Available: <input type="checkbox"/> Yes <input type="checkbox"/> No -- If No, Skip to Next Section			
Has the Patient Been Observed Walking 150 Feet or More: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes –Raw Ratings (rate levels 1-7)	Transfer: Bed, Chair _____	Expression _____	Transfers: Toilet _____
	Bowel Management _____	Locomotion: Walk _____	Memory _____
If No – Raw Ratings (rate levels 1-7)	Eating _____	Expression _____	Transfers :Toilet _____
	Bowel Management _____	Grooming _____	Memory _____
Projected:	FIM® projected Raw Motor (13):	FIM® projected Cognitive (5):	
	Help Needed:		
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<i>Insert Health Service Provider Logo</i>	<i>Patient Identification</i>	
Attachments		
Details on Other Relevant Information That Would Assist With This Referral:		
Please Include With This Referral: <ul style="list-style-type: none"> <input type="checkbox"/> Admission History and Physical <input type="checkbox"/> Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician) <input type="checkbox"/> All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.) <input type="checkbox"/> Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present) 		
Completed By:	Title:	Date: DD/MM/YYYY
Contact Number:	Direct Unit Phone Number:	