

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
 Client Details and Demographics and Supplementary Information



## eStroke RM&R System

ACUTE CARE TO INPATIENT REHAB REFERRAL FORM  
TRAINING

This referral form is considered the minimum information required to make a decision regarding appropriateness for rehabilitation - complete all fields.

CLIENT DETAILS			
Social Worker or person responsible for managing referrals to complete. Enter first and last name exactly as shown on the hospital card.			
Patient's First Name		Last Name	
Responsible Person*:			
Health Card Number *		Version	Expiry Date
Province/Territory Issuing Health Card	Referral Provider		Referral Provider is the person <u>managing</u> or responsible for referrals
DEMOGRAPHICS			
Patient DOB		YYYY-MM-DD	
MRN			
Does client have a permanent address? <input type="checkbox"/> Y <input type="checkbox"/> N			
Patient's Home Address		City	Province
Postal Code		Phone Number	
Does the patient have an alternate contact? <input type="checkbox"/> Y <input type="checkbox"/> N			
Alternate Contact Name		Phone Number	Relation to patient
Current Location*:			
SUPPLEMENTARY INFORMATION			
When was patient admitted to acute care? YYYY-MM-DD*			
Patient's Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other			
Bed Offer Contact: First Name		Last Name	Email address
Does the patient have a Primary Care Provider? <input type="checkbox"/> Y <input type="checkbox"/> N			
Primary Care Provider's Name			
Primary Care Provider's Contact Information (phone or fax)			
Primary Language Spoken <input type="checkbox"/> English <input type="checkbox"/> Other		If other indicate Primary Language Spoken	
Speaks, Understands English <input type="checkbox"/> Yes <input type="checkbox"/> No		Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Premorbid Vocational Status (before this encounter) (amended from CIHI-NRS)			
<input type="checkbox"/> Full time or 30 hrs/week	<input type="checkbox"/> Part-time <30 hrs/week	<input type="checkbox"/> Adjusted/modified work	<input type="checkbox"/> Student <input type="checkbox"/> Volunteer
<input type="checkbox"/> Retired	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Homemaker <input type="checkbox"/> Don't know
Type of vocation (Describe)			
Educational Level (choose HIGHEST level completed)			
<input type="checkbox"/> High School Grade 12	<input type="checkbox"/> High School Grade 13	<input type="checkbox"/> College Diploma	<input type="checkbox"/> University Degree
<input type="checkbox"/> Masters Degree	<input type="checkbox"/> Doctoral Degree	<input type="checkbox"/> Don't know	<input type="checkbox"/> Other (list)
Is patient ready to transfer to rehab within the next 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No		If early referral (e.g. patient to be weaned off of NG tube, IV out, dates) provide details in text box if special needs expected to resolve before discharge	
If NO, indicate Anticipated date ready for rehab or ready for transfer to rehab* MM/DD/YYYY			
Rehab Setting Type <input type="checkbox"/> Inpatient rehab High Intensity Rehab <input type="checkbox"/> Inpatient Low Intensity Rehab <input type="checkbox"/> Outpatient Rehab			
Accommodations <input type="checkbox"/> Private <input type="checkbox"/> Semi <input type="checkbox"/> Ward			
Additional Referral Comments			

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
ACUTE MEDICAL ASSESSMENT



<b>Physician or Physician Designate or Nurse Practitioner to complete</b> Complete the medical section in as much detail as possible. Fields marked * are mandatory		
<b>Date of Stroke Onset (or Date Last Seen Normal) *</b>		YYYY-MM-DD
<b>First Stroke? *</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Date Previous Stroke</b> YYYY-MM-DD	Deficits Previous Stroke - Provide information on physical and functional deficits prior to this admission
<b>Type of Stroke*</b> (current stroke)	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Transforming to Hemorrhagic	
<b>Stroke Location</b> (most recent CT/MRI)	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Frontal <input type="checkbox"/> Parietal <input type="checkbox"/> Occipital <input type="checkbox"/> Temporal <input type="checkbox"/> Internal Capsule <input type="checkbox"/> Basal ganglia <input type="checkbox"/> Thalamus <input type="checkbox"/> Cerebellum <input type="checkbox"/> Brainstem
<b>Deficits related to <u>Current</u> Stroke</b>		
<input type="checkbox"/> L Hemiparesis <input type="checkbox"/> R Hemiparesis <input type="checkbox"/> No Paresis <input type="checkbox"/> Aphasia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Apraxia <input type="checkbox"/> Neglect <input type="checkbox"/> Ataxia <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Visual Deficits <input type="checkbox"/> Visual Perceptual Deficits <input type="checkbox"/> Other (provide additional details):		
<b>Previous CT or MRI Findings</b>	<input type="checkbox"/> None <input type="checkbox"/> Evidence of previous infarcts <input type="checkbox"/> Sub cortical white matter changes - Mild <input type="checkbox"/> Sub cortical white matter changes - Moderate <input type="checkbox"/> Sub cortical white matter changes - Severe	
<b>Mechanism of Stroke</b>	<input type="checkbox"/> Carotid Stenosis Required Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No (IF YES, include details in surgical history below) <input type="checkbox"/> Cardioembolic <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Dilated Cardiomyopathy or other structural/wall movement abnormality <input type="checkbox"/> Valvular problem <input type="checkbox"/> Dissection <input type="checkbox"/> Carotid <input type="checkbox"/> Vertebral <input type="checkbox"/> Small Vessel Thrombosis <input type="checkbox"/> Auto Immune (include details in co-morbidity section below) <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Provide details)	Provide details for each mechanism checked, in the text box
<b>Treatment Received</b>	<input type="checkbox"/> Thrombolysis (e.g. t-PA) <input type="checkbox"/> Endovascular Treatment (include details in surgical history below)	
<b>Specific Conditions Impacting On Rehab Potential</b> <input type="checkbox"/> None on this list  <input type="checkbox"/> Angina <input type="checkbox"/> Coronary Artery Bypass Surgery or Stenting Procedure <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Amputation <input type="checkbox"/> Asthma <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Cerebral Vasculitis <input type="checkbox"/> Other (list):		<ul style="list-style-type: none"> <li>• Provide details of how these conditions and any other medical conditions not listed here may impact on ability to participate in rehab.</li> <li>• Use the text box to provide details.</li> </ul>

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
ACUTE MEDICAL ASSESSMENT



<p><b>Charleson Comorbidities Index</b></p> <p><input type="checkbox"/> No Comorbidities on <b>THIS</b> List</p> <table border="0"> <tr> <td><input type="checkbox"/> (1) Myocardial Infarct</td> <td><input type="checkbox"/> (1) Diabetes</td> </tr> <tr> <td><input type="checkbox"/> (1) Congestive Heart failure</td> <td><input type="checkbox"/> (2) Hemiplegia (Pre-existing)</td> </tr> <tr> <td><input type="checkbox"/> (1) Peripheral Vascular disease</td> <td><input type="checkbox"/> (2) Moderate or severe renal disease</td> </tr> <tr> <td><input type="checkbox"/> (1) Cerebrovascular disease</td> <td><input type="checkbox"/> (2) Diabetes with end organ damage</td> </tr> <tr> <td><input type="checkbox"/> (1) Dementia</td> <td><input type="checkbox"/> (2) Any tumor</td> </tr> <tr> <td><input type="checkbox"/> (1) Chronic pulmonary disease</td> <td><input type="checkbox"/> (2) Leukemia</td> </tr> <tr> <td><input type="checkbox"/> (1) Connective tissue disease</td> <td><input type="checkbox"/> (2) Lymphoma</td> </tr> <tr> <td><input type="checkbox"/> (1) Ulcer</td> <td><input type="checkbox"/> (3) Moderate or severe liver disease</td> </tr> <tr> <td><input type="checkbox"/> (1) Mild liver disease</td> <td><input type="checkbox"/> (3) AIDS</td> </tr> </table> <p><b>Other Comorbid Conditions of Significance (list):</b></p>	<input type="checkbox"/> (1) Myocardial Infarct	<input type="checkbox"/> (1) Diabetes	<input type="checkbox"/> (1) Congestive Heart failure	<input type="checkbox"/> (2) Hemiplegia (Pre-existing)	<input type="checkbox"/> (1) Peripheral Vascular disease	<input type="checkbox"/> (2) Moderate or severe renal disease	<input type="checkbox"/> (1) Cerebrovascular disease	<input type="checkbox"/> (2) Diabetes with end organ damage	<input type="checkbox"/> (1) Dementia	<input type="checkbox"/> (2) Any tumor	<input type="checkbox"/> (1) Chronic pulmonary disease	<input type="checkbox"/> (2) Leukemia	<input type="checkbox"/> (1) Connective tissue disease	<input type="checkbox"/> (2) Lymphoma	<input type="checkbox"/> (1) Ulcer	<input type="checkbox"/> (3) Moderate or severe liver disease	<input type="checkbox"/> (1) Mild liver disease	<input type="checkbox"/> (3) AIDS	<ul style="list-style-type: none"> <li>• Provide details in text box of all conditions checked</li> <li>• Indicate if new or existing comorbidities are stable or require monitoring and the current management plan. E.g. if patient has cancer note current diagnosis, status and current treatment including chemo meds/radiation</li> </ul>
<input type="checkbox"/> (1) Myocardial Infarct	<input type="checkbox"/> (1) Diabetes																		
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<input type="checkbox"/> (1) Mild liver disease	<input type="checkbox"/> (3) AIDS																		
<p><b>Previous Psychiatric History *</b> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>If Yes, mandatory to describe history and status in comment box</p>	<ul style="list-style-type: none"> <li>• Current status and care plan is required. Indicate if supports in place or required.</li> <li>• Consider any impact on <u>ability to participate in rehab, supports required</u></li> <li>• Provide summary of any consultation note or FAX consult note to rehab at time of application.</li> <li>• Contact Psychiatrist's name, number if available</li> </ul>																		
<p><b>Current Psychiatric Diagnosis *</b> No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>If Yes, mandatory to specify diagnosis and status in comment box</p>																			
<p><b>Surgical History/Planned Surgery</b></p> <p>Surgeries No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>List surgeries during this hospitalization/planned surgery with date:</p> <p>Complications/care plan resulting from surgery:</p>	<ul style="list-style-type: none"> <li>• Include details of surgeries during or recent surgeries prior to admission including: current status, care plan, wound care, follow up appointments, precautions required and any impact on <u>ability to participate in rehab</u> e.g. weight bearing status</li> <li>• Provide information relating to any planned surgery</li> </ul>																		
<p><b>Stroke Workup</b></p> <p><b>Echocardiogram</b></p> <p><input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ____/____/____ yy/mm/dd,</p>	<p><b>Ensure dates are provided if tests are booked.</b></p> <p><b>Holter Monitor</b></p> <p><input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ____/____/____ yy/mm/dd</p> <p><b>Carotid Imaging</b></p> <p><input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ____/____/____ yy/mm/dd</p> <p><b>*Secondary Prevention Clinic</b></p> <p><input type="checkbox"/> Booked * ____/____/____ yyyy/mm/dd <input type="checkbox"/> Referred</p>																		
<p><b>Referring Physician's Name</b></p>	<ul style="list-style-type: none"> <li>• Ensure attending physician name is completed if different from referring physician name</li> </ul>																		
<p><b>Attending Physician's Name*</b></p>																			
<p><b>Referring Nurse Practitioner's Name</b></p>																			

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## SOCIAL INFORMATION



It is essential to complete this section in as much detail as possible.		
<b>FINANCES</b>		
<b>Who manages the patient's FINANCES NOW?</b> <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Don't Know		
<b>If OTHERS, list contact information contact person, FINANCES</b>		
<b>Name</b>		
<b>Relationship to patient</b> <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
<b>PERSONAL CARE</b>		
<b>Who manages the patient's PERSONAL CARE decisions now?</b> <input type="checkbox"/> Self <input type="checkbox"/> Others		
<b>If others, list contact information</b> <input type="checkbox"/> Same as contact person, FINANCES OR		
<b>Contact Person, PERSONAL CARE decisions</b>		
<b>Name</b>		
<b>Relationship to patient</b> <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
<b>SUBSTITUTE DECISION MAKER</b>		
<b>Document if patient retains any of the following</b>		
<input type="checkbox"/> A substitute decision maker <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Public Guardian/Trustee <input type="checkbox"/> N/A		
<b>Contact information if applicable</b>		
<input type="checkbox"/> Same Contact, FINANCES <input type="checkbox"/> Same Contact, PERSONAL CARE <input type="checkbox"/> Other, see below.		
<b>If OTHER list contact information</b>		
<b>Name</b>		
<b>Relationship to patient</b> <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
<b>Financial Information</b> <i>Adapted from CIHI NRS</i>		
<input type="checkbox"/> WSIB <input type="checkbox"/> Private Insurance <input type="checkbox"/> OAS <input type="checkbox"/> Legal Settlement <input type="checkbox"/> Ontario Works <input type="checkbox"/> Self-employed <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Canadian Pension <input type="checkbox"/> No income <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Veteran <input type="checkbox"/> ODSP <input type="checkbox"/> EI		
<b>Responsibility for Payment</b> <i>Source: CIHI NRS</i>		
<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		
<b>If insurance payment</b>	Claim #	Certificate #
Name of insurer		
Group number	Policy #	

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
**SOCIAL INFORMATION (contd)**



<b>Marital Status:</b> <input type="checkbox"/> Single <span style="margin-left: 300px;"><input type="checkbox"/> Divorced</span> <input type="checkbox"/> Married <span style="margin-left: 300px;"><input type="checkbox"/> Widowed</span> <input type="checkbox"/> Common Law <span style="margin-left: 300px;"><input type="checkbox"/> Unknown</span> <input type="checkbox"/> Separated																				
<b>*Home living situation, living with:</b> (Adapted from CIHI-NRS) <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Family (including extended family) <input type="checkbox"/> Lives with others (includes retirement home or group home WITH supportive services, supportive living environment, live-in caregiver, LTC) <input type="checkbox"/> Living alone (includes retirement home with NO supports available) <input type="checkbox"/> Other (includes rooming house/boarding house/group home/shelter/hostel with NO supportive services available) * if this ticked, mandatory to complete below																				
<b>Caregiver support can be provided by:</b> <input type="checkbox"/> Spouse/partner <span style="margin-left: 300px;"><input type="checkbox"/> Roommate or Others</span> <input type="checkbox"/> Family (including extended family) <span style="margin-left: 300px;"><input type="checkbox"/> N/A</span>																				
<b>Premorbid additional support required:</b> <input type="checkbox"/> Attendant care <input type="checkbox"/> Home support <input type="checkbox"/> Privately-funded care <input type="checkbox"/> None  Provide information on premorbid function and existing supports required pre-admission.																				
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Can caregiver currently provide support with:</th> <th style="text-align: center; border-bottom: 1px solid black;">ADL*</th> <th style="text-align: center; border-bottom: 1px solid black;">IADL*</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> N/A, patient does not have a caregiver</td> <td></td> <td></td> </tr> <tr> <td>Willing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Able</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Available days</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Available evenings</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p><b>Comments caregiver support</b> Indicate post-rehab supports available and/or plans in progress (e.g. family to live with patient, able to assist, able to purchase equipment, securing retirement home):</p>			Can caregiver currently provide support with:	ADL*	IADL*	<input type="checkbox"/> N/A, patient does not have a caregiver			Willing	<input type="checkbox"/>	<input type="checkbox"/>	Able	<input type="checkbox"/>	<input type="checkbox"/>	Available days	<input type="checkbox"/>	<input type="checkbox"/>	Available evenings	<input type="checkbox"/>	<input type="checkbox"/>
Can caregiver currently provide support with:	ADL*	IADL*																		
<input type="checkbox"/> N/A, patient does not have a caregiver																				
Willing	<input type="checkbox"/>	<input type="checkbox"/>																		
Able	<input type="checkbox"/>	<input type="checkbox"/>																		
Available days	<input type="checkbox"/>	<input type="checkbox"/>																		
Available evenings	<input type="checkbox"/>	<input type="checkbox"/>																		
<b>Present accommodation:</b> <input type="checkbox"/> House <input type="checkbox"/> Residential Group Home <input type="checkbox"/> Apartment Building <input type="checkbox"/> Rooming house	<input type="checkbox"/> Unknown <input type="checkbox"/> Homeless <input type="checkbox"/> Other (list):																			
<b>Describe accommodation barriers that must be dealt with in order for patient to return home:</b> <input type="checkbox"/> Stairs into dwelling <input type="checkbox"/> Stairs to bathroom <input type="checkbox"/> Stairs to bedroom	<input type="checkbox"/> No barriers <input type="checkbox"/> Don't know <input type="checkbox"/> Other (list):																			
<b>Expected Discharge Destination Post Rehab:</b> <input type="checkbox"/> Home <input type="checkbox"/> Home, CCAC +/- paid help <input type="checkbox"/> Assisted Living (seniors apt building, retirement home) <input type="checkbox"/> LTC/CCC <input type="checkbox"/> Shelter/Hostel <input type="checkbox"/> Don't know <b>Comment:</b>																				

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
CARE REQUIREMENTS



<b>Nurse to complete</b>			
<p>* Is patient &gt; 250 lbs? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Weight*</b> _____ <input type="checkbox"/> Lbs <input type="checkbox"/> Kilos                  Hip Width: _____</p>	<p>Hip width is a mandatory field if patient is &gt; 250 lbs.</p> <p>Hip width measurement is defined as measurement from trochanter to trochanter</p>	<p><b>Height *</b> _____  <input type="checkbox"/> Inches  <input type="checkbox"/> Centimeters</p>	<p>Accuracy of height and weight is important for ensuring bariatric equipment is available in rehab</p>
<p><b>Vision</b>  <input type="checkbox"/> Adequate  <input type="checkbox"/> Impaired  <input type="checkbox"/> Glasses</p>	<p><b>Hearing</b>  <input type="checkbox"/> Adequate  <input type="checkbox"/> Impaired</p> <p><b>Uses Sign Language*</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Comments, Vision and Hearing</b> (list any hearing devices)</p>	
<p><b>Does the patient have any of the post stroke complications listed</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Fracture after a fall  <input type="checkbox"/> Venous thromboembolism  <input type="checkbox"/> Seizures  <input type="checkbox"/> Pneumonia</p> <p><b>Other complications (list):</b></p>		<p>Describe details of complications selected, and any other complications not on this list</p>	
<p><b>Allergies*</b>  <input type="checkbox"/> Drug Allergies <input type="checkbox"/> Food Allergies <input type="checkbox"/> Environmental Allergies  <input type="checkbox"/> Other Allergies <input type="checkbox"/> No Known Drug Allergies</p>		<p>Include any food or environmental allergies which impact care needs in text box</p>	
<p><b>Disorientated to:</b>  <input type="checkbox"/> Time <input type="checkbox"/> Person <input type="checkbox"/> Place</p> <p><b>Comments:</b></p>			
<p><b>Behaviour *</b>                  Check ALL that apply, at least one must be checked</p>		<p><input type="checkbox"/> Cooperative  <input type="checkbox"/> Resistive  <input type="checkbox"/> Aggressive  <input type="checkbox"/> Suicidal ideation  <input type="checkbox"/> Repetitive speech  <input type="checkbox"/> Screams  <input type="checkbox"/> Suspicious  <input type="checkbox"/> Abusive (physically)  <input type="checkbox"/> Anxious  <input type="checkbox"/> Sexually disinhibited</p>	<p><input type="checkbox"/> Self-mutilation  <input type="checkbox"/> Demanding  <input type="checkbox"/> Disruptive  <input type="checkbox"/> Depressed  <input type="checkbox"/> Repetitive movement  <input type="checkbox"/> Agitated (day)  <input type="checkbox"/> Agitated (sun downing)  <input type="checkbox"/> Abusive (verbally)  <input type="checkbox"/> Abusive (generally)  <input type="checkbox"/> Paranoid  <input type="checkbox"/> Exit Seeking</p>
<p><b>Comment on changes in cognition, behaviour during this admission and implications on future rehab.</b></p> <p><i>Note: if anything checked other than "Cooperative", mandatory to provide information in text box.</i></p>		<ul style="list-style-type: none"> <li>Describe changes and/or fluctuations in cognition, and behaviours during ALL nursing shifts</li> <li>Describe all management strategies used including use of <u>sitters</u> or family</li> <li>Indicate impact on ability to participate in rehab</li> </ul>	
<p><b>Overall impact of behavior on ADL</b></p> <p><input type="checkbox"/> None  <input type="checkbox"/> Mild  <input type="checkbox"/> Moderate  <input type="checkbox"/> Severe</p>			

# Toronto Stroke Rehab Referral System

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CARE REQUIREMENTS con't



Nurse to complete this section in as much detail as possible to allow rehab to determine if they can meet patient's current care requirements.		
<b>Safety and Support Required</b>		
<p><b>*Support required</b></p> <input type="checkbox"/> N/A <input type="checkbox"/> Geri chair <input type="checkbox"/> Bed rails <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Bed alarm <input type="checkbox"/> Chair alarm <input type="checkbox"/> Sitter/ observer <input type="checkbox"/> Other supports (List)	<p>If any of the boxes ticked except "N/A", complete text box</p> <ul style="list-style-type: none"> <li>• Include details related to use of bed/chair alarms/ specialized mattresses/ type of physical restraints if used. Indicate if any bariatric equipment is required.</li> <li>• Include frequency of use, time of day, effective strategies being used to manage the patient</li> <li>• For restraints: Include information if use of lap belt, wrist restraints, or any type of physical or chemical restraint used, etc</li> </ul>	<p><b>Restraints used *</b></p> <input type="checkbox"/> N/A <input type="checkbox"/> Physical <input type="checkbox"/> Chemical <p><b>Type/Reason for restraints</b></p> <p><b>Frequency:</b> _____ times per day/week/month</p>
<p><b>Wandering risk* If checked, mandatory to provide information in "Wandering Risk Comments"</b></p> <input type="checkbox"/> N/A <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor	<p>Include details related to wandering including: situations that exacerbate the behaviour, frequency, time of day, effective strategies being used to manage wandering e.g. wander guard</p>	
<p><b>Falls post stroke during this admission* If yes checked, mandatory to complete "Reason for fall", and provide information in "Reason for fall comment" box</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p><b>Frequency:</b> _____ times per day/week/month</p>	<p><b>Reason for fall:* (if Yes checked)</b></p> <input type="checkbox"/> Balance <input type="checkbox"/> Fatigue <input type="checkbox"/> Vision <input type="checkbox"/> Decreased insight, judgment <input type="checkbox"/> Strength <input type="checkbox"/> Other (list): _____	
<b>Special Needs *</b>		
<input type="checkbox"/> No special needs on list OR choose ALL that apply	<p><b>For EACH special need checked, provide treatment details, precautions and procedures. Indicate transportation needs when applicable:</b></p> <ul style="list-style-type: none"> <li>• Tracheotomy: type, corked or uncorked, cuff or un-cuffed</li> <li>• Suction: indicate frequency</li> <li>• Oxygen: continuous vs. intermittent, flow rate</li> <li>• IV Therapy: Central, PICC, Peripheral, Portacath</li> </ul> <p>** Note any other hospital acquired infections in the text boxes</p> <ul style="list-style-type: none"> <li>○ Date of symptom onset/diagnosis</li> <li>○ List of symptoms</li> <li>○ First test date and results</li> <li>○ Second test date and results</li> <li>○ Active chemotherapy, other special needs</li> <li>○ Any personal protective equipment required</li> <li>○ Type of precautions required for airborne droplets, contact and enhanced droplets</li> </ul> <ul style="list-style-type: none"> <li>• Peritoneal Dialysis and Hemodialysis: Indicate frequency of treatment, how patient will access treatment i.e family drives, volunteer drives, Wheeltrans or other</li> <li>• For enteral feeding: provide details of product, frequency and type of feed</li> <li>• Insulin pump: Patients need to be able to manage pump in rehab</li> <li>• CPAP or BiPAP: Indicate frequency use of machine is required, machine settings, hours of use, etc, and if patient can manage the machine independently. Include if aerosol generating. Note: Patients will need to bring own machine to rehab.</li> <li>• Cytotoxic Medications: Provide specific information of type of medications, if medication will be available from acute care if rehab is unable to provide</li> <li>• Active Chemotherapy: Indicate site treatment is provided/offered and frequency of treatment</li> <li>• Other Special Needs: Indicate patient's smoking needs; or drug/alcohol withdrawal needs (e.g. Methadone), or special equipment (e.g. bariatric)</li> </ul>	
<input type="checkbox"/> Tracheotomy <input type="checkbox"/> Suction <input type="checkbox"/> Oxygen <input type="checkbox"/> IV Therapy <input type="checkbox"/> Isolation** <input type="checkbox"/> COVID-19** <input type="checkbox"/> MRSA** <input type="checkbox"/> VRE** <input type="checkbox"/> C Difficile** <input type="checkbox"/> ESBL** <input type="checkbox"/> CRE** <input type="checkbox"/> Enteral Feeding† <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Insulin pump <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> Cytotoxic Medications <input type="checkbox"/> Active Chemotherapy <input type="checkbox"/> Other Special Needs		
<p>If anything other than "No special needs" is checked, mandatory to complete "Treatment details, Precautions, Procedures" text boxes</p> <p>If Hemodialysis ticked, mandatory to complete "Transportation needs" text box</p>		

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
**CARE REQUIREMENTS con't**



Skin condition			
<b>Ulcers present *</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> complete description and <b>Braden</b> staging grade:	<b>Description</b>		
	<table border="1"> <tr> <td><b>Size</b></td> <td><b>Location</b></td> </tr> </table>	<b>Size</b>	<b>Location</b>
	<b>Size</b>	<b>Location</b>	
Improving? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Other skin condition (list)</b>	Describe type of wound i.e. pressure/incisional/diabetic foot ulcer. Provide grade of wound I-IV. Include dressing regime if specialized e.g. VAC. Note if requires special mattress/bed		
<b>Bladder management*</b> <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Condom catheter <input type="checkbox"/> Using incontinent product <input type="checkbox"/> Toileting required <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Total incontinence	Provide details on relevant treatment, procedures and/or precautions		
<b>Bowel management*</b> <input type="checkbox"/> Continent <input type="checkbox"/> Toileting required <input type="checkbox"/> Occasional incontinence <input type="checkbox"/> Total incontinence <input type="checkbox"/> Using incontinent product			
<b>Ostomy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Type and care/products required		
Ability to care for ostomy: <input type="checkbox"/> Independent <input type="checkbox"/> Total care <input type="checkbox"/> Requires supervision <input type="checkbox"/> Requires assistance			
Describe nursing care plan required for ostomy			



# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
ALPHAFIM® INSTRUMENT



**PT/OT to complete**

- The AlphaFIM® Instrument provides a snapshot of the patient’s burden of care and helps assist in decision making for rehab referrals. Note: The most current details relating to status and management of bowel and bladder continence are provided in the nursing section of the referral
- Consultation with other team members required to ensure lowest score in 24 hours
- Day 3 (or earlier) AlphaFIM® Instrument scores are entered into the eStroke database for patients referred to stroke rehab within 7 days of stroke onset. In addition, a second score may be added to the referral if:
  - there has been a significant change in patient status
  - referrals are initiated or updated after Day 7

<b>Patient’s Name</b>	<b>DOB</b>	<b>YYYY-MM-DD</b>
<b>Tester Name</b>	<b>Date of Assessment</b>	<b>YYYY-MM-DD</b>

**AlphaFIM® scores completed:**  
 On or by day 3 (First Assessment)  
 Second Assessment  
 Third Assessment  
 Fourth Assessment

**Type of Stroke: (tick one)**  
 Stroke R body  
 Stroke L body  
 Stroke no paresis  
 Stroke bilateral  
 Other stroke

**Complete the AlphaFIM® Instrument items indicated below based on the distance the patient can currently walk.**

Patient walks less than 150ft		Patient walks 150ft or more		AlphaFIM® Instrument Rating Levels
Eating		Transfers: Bed Chair		<b>Note: leave no blanks Enter 1 if not able to test an item due to risk No HELPER</b> 7. Complete Independence (no device, timely, safely) 6. Modified Independence (device, not timely, or not safely) <b>Helper</b> <i>Modified Dependence (performs 50% or more of task)</i> 5. Supervision (patient performs 100% of the effort) 4. Minimal Assistance (patient performs 75% or more of the effort) 3. Moderate Assistance (patient performs 50% - 74% of the effort) <b>Complete Dependence (performs less than 50% of task)</b> 2. Maximal Assistance (patient performs 25% - 49% of the effort) 1. Total Assistance (patient performs < 25% of the effort)
Grooming		Walk		
Bowel Management		Bowel Management		
Transfers: Toilet		Transfers: Toilet		
Expression		Expression		
Memory		Memory		

**Comments:**

**Projected Scores from AlphaFIM® Instrument software at [www.udsmr.org](http://www.udsmr.org) (select software portal, AlphaFIM® software).**

If bowel scored 7 indicate in comment section if due to:  
 a) Absence of bowel movement in last 24 hours  
 b) Patient fully continent.

FIM® 13 Raw Motor

FIM® 5 Raw Cognition

FIM® 13 Rasch Motor

FIM® 5 Rasch Cognition

FIM® Motor Range

FIM® Cognition Range

FIM® Walking Range

Help Needed

Projected scores are calculated using the AlphaFIM® Instrument software.

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# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
ORPINGTON PROGNOSTIC SCALE



Orpington Prognostic Scale TIPS for Completion document available as a link on this page or in REFERENCES Section

<b>PT/OT to complete</b>		
<b>Orpington Prognostic Scale: Grade the patient by CIRCLING the appropriate scores below.</b>		
<b>Motor deficit in arm Lying supine, patient flexes shoulder to 90 degrees and is given resistance</b>		<p style="text-align: center;"><b>Total Orpington Prognostic Score</b></p> <p style="text-align: center;">1.6 + Motor score + Proprioception + Balance score + Cognition Score = _____</p>
MRC grade 5 (normal power)	0	
MRC grade 4 (diminished power)	0.4	
MRC grade 3 (movement against gravity)	0.8	
MRC grade 1-2 (movement with gravity eliminated or trace)	1.2	
MRC grade 0 (no movement)	1.6	
<b>Proprioception (eyes closed) Locates affected thumb</b>		
Accurately	0	
Slight difficulty	0.4	
Finds thumb via arm	0.8	
Unable to find thumb	1.2	
<b>Balance</b>		<p style="text-align: center;"><b>Interpretation of Stroke Severity Score:</b></p> <p style="text-align: center;">&lt; 3.2 score = 3 minor stroke 3.2-5.2 score = 1 moderate stroke &gt; 5.2 score = -1 major stroke</p>
Walks 10 feet without help	0	
Maintains standing position	0.4	
Maintains sitting position	0.8	
No sitting balance	1.2	
<b>Cognition (Hodgkins Mental test): Can the patient recall.....</b> Hodgkins Mental Test score: options are 0.0, 0.4, 0.8, 1.2		<p style="text-align: center;"><b>Scoring Cognition (Score out of 10):</b></p> <p style="text-align: center;">Mental score 10 = 0.0 Mental score 8-9 = 0.4 Mental score 5-7 = 0.8 Mental score 0-4 = 1.2</p>
1. Age of the patient	1	
2. Time (to the nearest hour)	1	<p><b>Strategies for Aphasic Patients</b></p> <ul style="list-style-type: none"> <li>• Provide 3 choices written down if necessary for each question – allow patient to point to answer</li> <li>• Provide a yes/no answer to a question and provide sufficient time for patient to answer e.g.; <ul style="list-style-type: none"> <li>○ Patients age – provide 3 choices and yes/no answer</li> <li>○ Time – provide 3 choices and yes/no answer or use a clock and allow patient to point</li> </ul> </li> </ul>
<i>(Prompt by you) I am going to give you an address, please remember it and I will ask you later: 42 West St</i>		
3. Name of hospital	1	
4. Year	1	
5. Date of birth of patient	1	
6. Month	1	
7. Years of Second World War (1939-1945) (approximate range okay)	1	
8. Name of President of the United States	1	
9. Count backwards from 20	1	
10. What is the address I asked you to remember?	1	

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
**ORPINGTON PROGNOSTIC SCALE**



PT/OT to complete			
<b>Stroke Modifiers</b>	-1 <input type="checkbox"/>	Coma at onset of stroke	
	+1 <input type="checkbox"/>	Pure motor deficit	
	-1 <input type="checkbox"/>	Visuospatial deficit	(Draw a clock face with the time of 10 minutes after 11 am, OR if the patient cannot draw, have patient observe a clock and tell the time, or complete line bisection test)
	+1 <input type="checkbox"/>	Lacunar infarct	<b>Parietal symptoms may include:</b> <ul style="list-style-type: none"> <li>• <b>Anosognosia:</b> ignorance or lack of awareness of deficit</li> <li>• <b>Finger Agnosia:</b> inability to name individual fingers such as the thumb or finger</li> <li>• <b>Right-to-left Confusion:</b> inability to tell whether the hand, foot or arm of the examiner is on the right or left side of the body</li> <li>• <b>Acuculia:</b> impairment of simple arithmetic</li> <li>• <b>Agraphia:</b> impairment of ability to write</li> </ul>
	-2 <input type="checkbox"/>	Bihemispheric deficit	
	-1 <input type="checkbox"/>	Dysphagia	
	-2 <input type="checkbox"/>	Parietal Symptoms	
-1 <input type="checkbox"/>	Incontinence persists 2 weeks or longer post stroke	Does the patient have neurologic bladder incontinence (i.e. unrelated to inability to get to a toilet in time as a result of weakness) that persists for more than 2 weeks post stroke onset?	
<b>Patient Modifiers</b>	+2 <input type="checkbox"/>	Age <55 years	
	-3 <input type="checkbox"/>	Severe cardiovascular disease CCS Class III-IV and/or NYHA Class III-IV Angina	Please confirm the existence of severe cardiac or respiratory disease or symptomatic PVD disease with NP or MD
	-3 <input type="checkbox"/>	Severe respiratory disease Dyspnea Class III-IV	
	-1 <input type="checkbox"/>	Coexistent symptomatic PVD	
	-1 <input type="checkbox"/>	Poor premorbid functioning	
<b>Time Modifiers</b>	+2 <input type="checkbox"/>	Time elapse since stroke < 2 weeks	
	0 <input type="checkbox"/>	Time elapsed since stroke = 2-4 weeks	
	-1 <input type="checkbox"/>	Time elapsed since stroke = 4-8 weeks	
	-2 <input type="checkbox"/>	Time elapsed since stroke > 8 weeks	
<b>Modified Orpington Score</b> (Sum of modifiers PLUS stroke severity score from previous page) ..... <b>If final score is <math>\geq 0</math> Client is a candidate for active IP rehab programs or home rehab.</b> <b>If final score is &lt; 0 Client is a candidate for low tolerance rehabilitation programs</b>			
<b>If unable to complete the Orpington, Indicate reason</b>		If unable to complete the Orpington indicate reason. Consultation with SLP may be required to complete the Orpington for patients with aphasia	

<b>OT/PT to complete</b>	
<p>Was a COPM completed for this episode? <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES, complete the COPM</p> <p><b>If NO, Unable to complete COPM (provide reason)</b></p> <p><input type="checkbox"/> Language barrier with no translation available</p> <p><input type="checkbox"/> Aphasia without available support</p> <p><input type="checkbox"/> COPM© not currently implemented in organization</p> <p><input type="checkbox"/> Other (list below):</p> <p><b>If Other select – Describe reason unable to complete</b></p>	
<b>Tester First Name</b>	<b>Last Name</b>
<b>Tester Phone Number</b>	<b>Extension</b>
<b>Completed:</b>	<b>Assessment Date YYYY-MM-DD</b>
<p><b>Scoring</b></p> <p><b>PERFORMANCE (How would you rate the way you do this activity now?)</b></p> <p>1 = not able to do it at all, 10 = able to do it extremely well</p> <p><b>Satisfaction (How satisfied are you with the way you do this activity now?)</b></p> <p>1 = not satisfied at all, 10 = extremely satisfied</p>	
<p>How many Occupational Performance Problems has the patient identified?</p>	
<p><b>Occupational Performance Problem 1</b></p> <p>Describe: Rate Importance:</p>	<p>Up to 5 Occupational Performance Problems can be identified and rated</p>
<p><b>Occupational Performance Problem 2</b></p> <p>Describe: Rate Importance:</p>	
<p><b>Occupational Performance Problem 3</b></p> <p>Describe: Rate Importance:</p>	
<p><b>Occupational Performance Problem 4</b></p> <p>Describe: Rate Importance:</p>	
<p><b>Occupational Performance Problem 5</b></p> <p>Describe: Rate Importance:</p>	
<p><b>Additional Information</b></p>	
<p>How many additional Occupational Performance Problems has the patient identified? – Maximum of 10</p>	
<p><b>Notes and Observations</b></p>	

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
**FUNCTIONAL ASSESSMENT**



<b>PT/OT to complete</b>																		
<b>Functional Status* - Comment on current function and patient's PROGRESS (functional gains) since admission and implications for future rehab:</b>		<ul style="list-style-type: none"> <li>Describe stroke deficits, including strength, coordination, sensation, balance (CMSA stages if available)</li> <li>Describe current functional status (bed mobility, transfers, ambulation, type of gait aids, distance, ADL's, level of assistance required)</li> <li>Describe objective, measurable progress demonstrated</li> <li>Provide information about <u>premorbid</u> function</li> </ul>																
<b>Ability to participate – current status:</b> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><b>Physical Activity tolerance *</b></td> <td style="width:33%; border: none;"><b>Sitting tolerance *</b></td> <td style="width:33%; border: none;"><b>Mental Activity Tolerance *</b></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 15-30 minutes</td> <td style="border: none;"><input type="checkbox"/> <b>Supported</b></td> <td style="border: none;"><input type="checkbox"/> 15-30 minutes</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 30-60 minutes</td> <td style="border: none;"><input type="checkbox"/> 15-30 minutes</td> <td style="border: none;"><input type="checkbox"/> 30-60 minutes</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> &gt; 1 hour</td> <td style="border: none;"><input type="checkbox"/> 30-60 minutes</td> <td style="border: none;"><input type="checkbox"/> &gt;1 hour</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> &gt;1 hour</td> <td style="border: none;"><input type="checkbox"/> &gt;1 hour</td> </tr> </table> <p><b>Frequency of activity/therapy treatment tolerated:</b>   <input type="checkbox"/> Daily   <input type="checkbox"/> Multiple times / day   <input type="checkbox"/> 2-3 x per week   <input type="checkbox"/> Weekly</p>				<b>Physical Activity tolerance *</b>	<b>Sitting tolerance *</b>	<b>Mental Activity Tolerance *</b>	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> <b>Supported</b>	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> > 1 hour	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> >1 hour		<input type="checkbox"/> >1 hour	<input type="checkbox"/> >1 hour
<b>Physical Activity tolerance *</b>	<b>Sitting tolerance *</b>	<b>Mental Activity Tolerance *</b>																
<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> <b>Supported</b>	<input type="checkbox"/> 15-30 minutes																
<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 30-60 minutes																
<input type="checkbox"/> > 1 hour	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> >1 hour																
	<input type="checkbox"/> >1 hour	<input type="checkbox"/> >1 hour																
<b>Comment on changes or limitations in PARTICIPATION during this admission and implications for future rehab:</b>		<ul style="list-style-type: none"> <li>Describe any limitations impacting participation e.g. pain, fatigue, behaviours and effective strategies used to promote participation</li> </ul>																
<b>Motivation to participate in rehabilitation (choose One)</b> <input type="checkbox"/> Demonstrates motivation to participate in rehab (regular attendance and involvement, cooperation) <input type="checkbox"/> Usually motivated to participate, occasional frustration apparent <input type="checkbox"/> Motivated to participate but attendance, involvement or cooperation irregular																		
<b>Is the patient experiencing shoulder pain?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Comment:</b>																		
<b>Can patient take direction, execute and RETAIN verbal OR written OR visual instructions?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No																		
<b>Anticipated Progress:</b> √ the column matching anticipated independence by end of next rehab setting	<b>Independent with or without aids</b>	<b>Minimal assistance</b>	<b>Moderate to maximal assistance</b>															
Locomotion																		
Transfers																		
ADL																		
IADL																		
Other (list)																		
<b>Additional services:</b> <input type="checkbox"/> Pain management <input type="checkbox"/> Self-care & mobility assessment prescription																		

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
**FUNCTIONAL ASSESSMENT – con't**



<b>PT/OT to complete</b>			
<b>Visual Perceptual Status – Attention*</b> <input type="checkbox"/> Normal <input type="checkbox"/> Mild Inattention <input type="checkbox"/> Moderate Inattention <input type="checkbox"/> Severe Inattention		<b>Visual Perceptual status*</b> <input type="checkbox"/> Body neglect <input type="checkbox"/> Reduced depth perception <input type="checkbox"/> Affected spatial awareness/skills <input type="checkbox"/> Apraxia <input type="checkbox"/> Visual field deficit	
<b>Cognition – Attention*</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	<b>Memory *</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	<b>Judgment *</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	<b>Executive Functioning *</b> <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test
<b>MoCA Score completed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes indicate score ___/30		A score <26 warrants ongoing cognitive assessment	
<b>Comments on COGNITION - Describe Impact of Cognition and Perception on Function <u>during this admission*</u></b>  <b>If any of mild/moderate/severe checked, mandatory to complete text box</b>		<b>Describe</b> <ul style="list-style-type: none"> <li>• Premorbid functional status</li> <li>• Impact of cognition/ perception on rehab potential</li> <li>• Status of orientation</li> <li>• If patient can follow directions (verbal or non-verbal)</li> <li>• Mood</li> <li>• If visual field deficit is compensated or not</li> <li>• Results of any other cognitive/perceptual screening tests</li> <li>• Objective and measurable change where possible</li> <li>• Description of any effective management strategies</li> <li>• Comment on reasons unable to test cognition</li> </ul>	
<b>In your opinion, rate the patient's progress during this admission</b> <input type="checkbox"/> Marked progress <input type="checkbox"/> Moderate progress <input type="checkbox"/> Minimal progress <input type="checkbox"/> Patient has plateaued in progress <input type="checkbox"/> Patient is too acute to measure progress <input type="checkbox"/> Other (comment)			
<b>Comment, RATE OF PROGRESS</b>			

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
COMMUNICATION AND SWALLOWING



<b>SLP to complete</b>			
<b>Is Speech Language Pathologist involved with this patient</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Communication Disorder</b> <input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Both new and old		<b>Speech*</b> <input type="checkbox"/> Adequate <input type="checkbox"/> Receptive aphasia <input type="checkbox"/> Expressive aphasia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Apraxia <input type="checkbox"/> Cognitive communication deficit <input type="checkbox"/> Voice disorder	
		<b>Communicates</b> <input type="checkbox"/> Adequately <input type="checkbox"/> With Difficulty <input type="checkbox"/> Unable	
<b>Current status and changes in <u>COMMUNICATION</u> during this admission</b>  <b>Changes in Communication*</b>		<ul style="list-style-type: none"> <li>Describe speech/language functional deficits, communication strategies</li> <li>Can the patient follow directions?</li> <li>Premorbid function, need for interpreter</li> <li>Describe objective, measurable progress shown by patient</li> </ul>	
<b>Swallowing Disorder *</b> <input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Both new and old		<b>Phase Swallowing Affected</b> <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Oral <input type="checkbox"/> Both <input type="checkbox"/> Esophageal	
<b>Current status and changes in <u>SWALLOWING</u> during this admission and implications for future rehab:*</b>		<b>Describe</b> <ul style="list-style-type: none"> <li>Identify physiology/anatomy affected.</li> <li>Any esophageal issues</li> <li>Results of clinical and/or instrumental assessment</li> <li>Current treatment plan , describe objective and measurable progress shown</li> </ul>	
<b>Has videofluoroscopy been performed on this admission?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Repeat/videofluoroscopy recommended?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Diet *</b> <input type="checkbox"/> Regular <input type="checkbox"/> NPO <input type="checkbox"/> NG <input type="checkbox"/> GJ <input type="checkbox"/> J <input type="checkbox"/> G		<b>Adjusted diet: solids</b> <input type="checkbox"/> Minced diet <input type="checkbox"/> Pureed diet <input type="checkbox"/> Dental soft diet <input type="checkbox"/> Snacks only <input type="checkbox"/> Other (list below):	
		<b>Adjusted diet: liquids</b> <input type="checkbox"/> Thin liquids <input type="checkbox"/> Nectar thick liquids <input type="checkbox"/> Honey thick liquids <input type="checkbox"/> Pudding <input type="checkbox"/> Sips of water only <input type="checkbox"/> G-tube feeds <input type="checkbox"/> Other (list below):	
<b>Changes in DIET during this admission and implications for future rehab</b>		<ul style="list-style-type: none"> <li>Texture (progress, tolerance and adequacy). In collaboration with dietician indicate if poor PO intake</li> <li>Anticipated progress</li> </ul>	
<b>Anticipated Progress:</b> √ the column matching anticipated level of independence by end of next rehab setting	<b>Independent with or without aids</b>	<b>Minimal assistance</b>	<b>Moderate to maximal assistance</b>
Communication			
Feeding			
<b>Impact of communication disorder(s) on behavior</b> <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
<b>Speech, language and diet comments:</b>		<ul style="list-style-type: none"> <li>Anticipated progress</li> <li>Any limitations</li> </ul>	

# Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM – TRAINING  
CALCULATIONS and CLIENT CHOICE



## CALCULATIONS

Person managing and responsible for sending referrals/ Allied Health must click “Calculate Scores” Button (Top Left of screen) to ensure all total scores are calculated and appear in corresponding fields.

Click “Calculate Scores” when all information in the referral is accurate and complete, and the referral is ready to be sent

Scores include:

- Projected Raw Score from AlphaFIM® Total
- Charlson Comorbidities Score
- Total Orpington Prognostic Score
- Stroke Severity Score

## CLIENT CHOICE

Social Worker or person managing and responsible for referrals to complete

Planned referral destination/s (Apply to maximum of 2 rehab facilities based on closest to home/discharge destination and/or patient preference. If rehab organizations are unable to admit within 2 days, apply to an additional 2 sites )

- |    |    |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. |    |

Indicate if patient has a preferred choice for rehab destination. Rate in order of preference based on closest rehab to planned discharge destination