Toronto Stroke Networks

Toronto eStroke Rehab RM&R System

ACUTE CARE TO INPATIENT REHAB REFERRAL FORM

Please complete all fields and send referral electronically through **eStroke** or fax a copy of this form to the stroke rehab program if outside of Toronto.

CLIENT DETAILS

Patient's First Name	**Last Name**	
Responsible Person*:		
Health Card Number *	**Version**	**Expiry Date**
Province/Territory Issuing Health Card	**Referral Provider**	

DEMOGRAPHICS

Patient DOB	**YYYY-MM-DD**	
MRN		
Does client have a permanent address? ☐ Y ☐ N		
Patient's Home Address	**City**	**Province**
Postal Code	**Phone Number**	
Does the patient have an alternate contact? ☐ Y ☐ 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 ☐ M ☐ F ☐ **Other**

Bed Offer Contact: First Name **Last Name** **Email address**

Does the patient have a Primary Care Provider? ☐ Y ☐ N

Primary Care Provider's Name

Primary Care Provider's Contact Information (phone or fax)

Primary Language Spoken ☐ English ☐ Other If other indicate **Primary Language Spoken**

Speaks, Understands English ☐ Yes ☐ No Interpreter Needed? ☐ Yes ☐ No

Premorbid Vocational Status (before this encounter) (amended from CIHI-NRS)

☐ Full time or 30 hrs/week ☐ Part-time <30 hrs/week ☐ Adjusted/modified work ☐ Student ☐ Volunteer
☐ Retired ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Don't know

Type of vocation (Describe)

Educational Level (choose HIGHEST level completed)

☐ High School Grade 12 ☐ High School Grade 13 ☐ College Diploma ☐ University Degree
☐ Masters Degree ☐ Doctoral Degree ☐ Don't know ☐ Other (list)

Is patient ready to transfer to rehab within the next 24 hours? ☐ Yes ☐ No **If NO, indicate Anticipated date ready for rehab or ready for transfer to rehab*** **MM/DD/YYYY**	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

Rehab Setting Type

☐ **Inpatient rehab High Intensity Rehab** ☐ **Inpatient Low Intensity Rehab** ☐ **Outpatient Rehab**

Apply to maximum of 2 rehab facilities based on closest to home/discharge destination and/or patient preference. Indicate patient preferred choice

Additional Referral Comments

* MANDATORY - Electronic Referral cannot be made without completion of this field

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ACUTE TO INPATIENT REHAB REFERRAL FORM

ACUTE MEDICAL ASSESSMENT

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Patient's Name:		
Physician or Physician Designate or Nurse Practitioner to complete Complete the medical section in as much detail as possible. Fields marked * are mandatory		
Date of Stroke Onset (or Date Last Seen Normal) *	**YYYY-MM-DD**	
First Stroke? * ☐ **Yes** ☐ **No**	**Date Previous Stroke**	**YYYY-MM-DD**
Type of Stroke* (current stroke)	☐ Ischemic ☐ Hemorrhagic ☐ Transforming to Hemorrhagic	
Stroke Location (most recent CT/MRI)	☐ Left ☐ Right ☐ Both	☐ Frontal ☐ Parietal ☐ Occipital ☐ Temporal ☐ Internal Capsule ☐ Basal ganglia ☐ Thalamus ☐ Cerebellum ☐ Brainstem
Deficits related to <u>Current</u> Stroke ☐ L Hemiparesis ☐ R Hemiparesis ☐ No Paresis ☐ Aphasia ☐ Dysphagia ☐ Apraxia ☐ Neglect ☐ Ataxia ☐ Cognitive Impairment ☐ Visual Deficits ☐ Visual Perceptual Deficits ☐ Other (provide additional details):		
Previous CT or MRI Findings	☐ None ☐ Evidence of previous infarcts ☐ Sub cortical white matter changes - Mild ☐ Sub cortical white matter changes - Moderate ☐ Sub cortical white matter changes - Severe	
Mechanism of Stroke	☐ Carotid Stenosis Required Surgery? ☐ Yes ☐ No *(IF YES, include details in surgical history below)* ☐ Cardioembolic ☐ Atrial Fibrillation ☐ Dilated Cardiomyopathy or other structural/wall movement abnormality ☐ Valvular problem ☐ Dissection ☐ Carotid ☐ Vertebral ☐ Small Vessel Thrombosis ☐ Auto Immune *(include details in co-morbidity section below)* ☐ Unknown ☐ Other (Provide details)	
Treatment Received	☐ Thrombolysis (e.g. t-PA) ☐ Endovascular Treatment (include details in surgical history below)	

Specific Conditions Impacting On Rehab Potential

☐ **None on this list**
☐ Angina
☐ Coronary Artery Bypass Surgery or Stenting Procedure
☐ Atrial Fibrillation
☐ Arthritis
☐ Osteoporosis
☐ Amputation
☐ Asthma
☐ Systemic Lupus Erythematosis
☐ Cerebral Vasculitis
☐ Other (list):

Toronto eStroke Rehab RM&R System

ACUTE TO INPATIENT REHAB REFERRAL FORM

ACUTE MEDICAL ASSESSMENT

Toronto Stroke Networks

Patient's Name:

Charleson Comorbidities Index

☐ No Comorbidities on **THIS** List

☐(1) Myocardial Infarct
☐(1) Congestive Heart failure
☐(1) Peripheral Vascular disease
☐(1) Cerebrovascular disease
☐(1) Dementia
☐(1) Chronic pulmonary disease
☐(1) Connective tissue disease
☐(1) Ulcer
☐(1) Mild liver disease

☐(1) Diabetes
☐(2) Hemiplegia (Pre-existing)
☐(2) Moderate or severe renal disease
☐(2) Diabetes with end organ damage
☐(2) Any tumor
☐(2) Leukemia
☐(2) Lymphoma
☐(3) Moderate or severe liver disease
☐(3) AIDS

The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores > 3 may not tolerate rehabilitation

Other Comorbid Conditions of Significance
(list):_____

Previous Psychiatric History * **No** ☐ **Yes** ☐
If Yes, mandatory to describe history and status in comment box

Current Psychiatric Diagnosis * **No** ☐ **Yes** ☐
If Yes, mandatory to specify diagnosis and status in comment box

Surgical History/Planned Surgery

Surgeries **No** ☐ **Yes** ☐

List surgeries during this hospitalization/planned surgery with date: _____

Complications/care plan resulting from surgery:_____

Stroke Workup

Echocardiogram
☐ Done
☐ Not indicated
☐ Booked ____/__/__ yy/mm/dd

Holter Monitor
☐ Done
☐ Not indicated
☐ Booked ____/__/__ yy/mm/dd

Carotid Imaging
☐ Done
☐ Not indicated
☐ Booked ____/__/__ yy/mm/dd

***Secondary Prevention Clinic**
☐ Booked *____/*__/*__ yyyy/mm/dd
☐ Referred

Referring Physician's Name	**Date**	YYYY-MM-DD
Attending Physician's Name*	**Date**	YYYY-MM-DD
Referring Nurse Practitioner's Name	**Date**	YYYY-MM-DD

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Toronto eStroke Rehab RM&R System

ACUTE TO INPATIENT REHAB REFERRAL FORM

SOCIAL INFORMATION

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Patient's Name:			
FINANCES			
Who manages the patient's FINANCES NOW? ☐ Self ☐ Others ☐ Don't Know			
If OTHERS, list contact information contact person, FINANCES **Name** **Relationship to patient** ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other			
Address		Postal Code	
Daytime Phone		Evening Phone	
PERSONAL CARE			
Who manages the patient's PERSONAL CARE decisions now? ☐ Self ☐ Others			
If others, list contact information ☐Same as contact person, **FINANCES OR**			
Contact Person, PERSONAL CARE decisions **Name** **Relationship to patient** ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other			
Address		Postal Code	
Daytime Phone		Evening Phone	
SUBSTITUTE DECISION MAKER			
Document if patient retains any of the following ☐ A substitute decision maker ☐ Power of Attorney ☐ Guardian ☐ Public Guardian/Trustee ☐ N/A			
Contact information if applicable ☐Same Contact, FINANCES ☐ Same Contact, PERSONAL CARE ☐ Other, see below.			
If OTHER list contact information **Name** **Relationship to patient** ☐Spouse ☐ partner ☐ son or daughter ☐ sibling ☐relative ☐ friend ☐ appointed ☐other			
Address		Postal Code	
Daytime Phone		Evening Phone	
Financial Information *Adapted from CIHI NRS* ☐WSIB ☐Private Insurance ☐OAS ☐Legal Settlement ☐Ontario Works ☐Self-employed ☐Short Term Disability ☐Canadian Pension ☐No income ☐Long Term Disability ☐Auto Insurance ☐Veteran ☐ODSP ☐EI			
Responsibility for Payment *Source: CIHI NRS* ☐OHIP ☐Federal Government ☐IFH (Interim Federal Health Grant) ☐Inter-provincial Insurance Plan ☐Insured/Self Pay ☐Other Payment Sources ☐WSIB ☐Uninsured/Self Pay ☐Unknown			
If insurance payment Name of insurer	Claim #	Certificate #	
Group number	Policy #		

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

SOCIAL INFORMATION (cont'd)

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Patient's Name:

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Common Law
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

***Home living situation, living with:** (Adapted from CIHI-NRS)

- ☐ Spouse/partner
- ☐ Family (including extended family)
- ☐ Lives with others (includes retirement home or group home WITH supportive services, supportive living environment, live-in caregiver, LTC)
- ☐ Living alone (includes retirement home with NO supports available)
- ☐ Other (includes rooming house/boarding house/group home/shelter/hostel with NO supportive services available) * *if this ticked, mandatory to complete below*

Caregiver support can be provided by:

- ☐ Spouse/partner
- ☐ Family (including extended family)
- ☐ Roommate or Others
- ☐ N/A

Premorbid additional support required:

- ☐ Attendant care
- ☐ Home support
- ☐ Privately-funded care
- ☐ None

Provide information on premorbid function and existing supports required pre-admission.

Can caregiver currently provide support with: ☐ **N/A**, patient does not have a caregiver	**ADL***	**IADL***
Willing	☐	☐
Able	☐	☐
Available days	☐	☐
Available evenings	☐	☐

Comments caregiver support 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)**:**

Present accommodation:

- ☐ House
- ☐ Residential Group Home
- ☐ Apartment Building
- ☐ Rooming house
- ☐ Unknown
- ☐ Homeless
- ☐ Other (list):

Describe accommodation barriers that must be dealt with in order for patient to return home:

- ☐ Stairs into dwelling
- ☐ Stairs to bathroom
- ☐ Stairs to bedroom
- ☐ No barriers
- ☐ Don't know
- ☐ Other (list):

Expected Discharge Destination Post Rehab:

- ☐ Home
- ☐ Home, CCAC +/- paid help
- ☐ Assisted Living (seniors apt building, retirement home)
- ☐ LTC/CCC
- ☐ Shelter/Hostel
- ☐ Don't know

Comment:

Completed by:	**Date:**

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Toronto eStroke Rehab RM&R System

ACUTE TO INPATIENT REHAB REFERRAL FORM

CARE REQUIREMENTS

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Patient's Name:

Nurse to complete

* Is patient > 250 lbs? ☐ **Yes** ☐ **No Weight***_____ ☐ Lbs ☐ Kilos

Hip Width:_____

Height *_____
☐ Inches
☐ Centimeters

Vision
☐ Adequate
☐ Impaired
☐ Glasses

Hearing
☐ Adequate
☐ Impaired

Uses Sign Language*
☐ **Yes** ☐ **No**

Comments, Vision and Hearing (list any hearing devices)

Does the patient have any of the post stroke complications listed ☐ **Yes** ☐ **No**

☐ Fracture after a fall
☐ Venous thromboembolism
☐ Seizures
☐ Pneumonia

Other complications (list):

Allergies*
☐ **Drug Allergies** ☐ **Food Allergies** ☐ **Environmental Allergies** ☐ **Other Allergies** ☐ **No Known Drug Allergies**

List Allergies:

Disorientated to:

☐ Time ☐ Person ☐ Place

Comments:

Behaviour *

Check ALL that apply, at least one must be checked

☐ Cooperative
☐ Resistive
☐ Aggressive
☐ Suicidal ideation
☐ Repetitive speech
☐ Screams
☐ Suspicious
☐ Abusive (physically)
☐ Anxious
☐ Sexually disinhibited
☐ Self-mutilation
☐ Demanding
☐ Disruptive
☐ Depressed
☐ Repetitive movement
☐ Agitated (day)
☐ Agitated (sun downing)
☐ Abusive (verbally)
☐ Abusive (generally)
☐ Paranoid
☐ Exit Seeking

Comment on changes in cognition, behaviour during this admission and implications on future rehab*.

Overall impact of behavior on ADL
☐ None
☐ Mild
☐ Moderate
☐ Severe

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ACUTE TO INPATIENT REHAB REFERRAL FORM

CARE REQUIRMENTS con't

Toronto Stroke Networks

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.

Safety and Support Required

***Support required**

☐ **N/A**
☐ Geri chair
☐ Bed rails
☐ Hoyer lift
☐ Bed alarm
☐ Chair alarm
☐ Sitter/ observer
☐ Other supports (List)

Restraints used *

☐ **N/A**
☐ Physical
☐ Chemical

Type/Reason for restraints

Frequency: times per day/week/month

Wandering risk* If checked, mandatory to provide information in "Wandering Risk Comments"

☐ **N/A**
☐ Indoor
☐ Outdoor

Falls post stroke during this admission* If yes checked, mandatory to complete "Reason for fall", and provide information in "Reason for fall comment" box

☐**Yes** ☐ **No**

Frequency: times per day/week/month

Reason for fall:* (if Yes checked)

☐ Balance
☐ Vision
☐ Strength
☐ Fatigue
☐ Decreased insight, judgment
☐ Other (list):

Special Needs *

☐**No special needs on list OR choose ALL that apply**

☐**Tracheotomy**
☐**Suction**
☐**Oxygen**
☐**IV Therapy**
☐**Isolation****
☐**COVID-19****
☐**MRSA****
☐**VRE****
☐**C Difficile****
☐**ESBL****
☐**CRE****
☐**Enteral Feeding†:**
☐**Peritoneal Dialysis**
☐**Hemodialysis**
☐**Insulin pump**
☐**CPAP**
☐**BiPAP**
☐**Cytotoxic Medications**
☐**Active Chemotherapy**
☐**Other Special Needs**

If anything other than "No special needs" is checked, mandatory to complete "Treatment details, Precautions, Procedures" text boxes

If Hemodialysis ticked, mandatory to complete "Transportation needs" text box

Treatment

Precautions

Procedure

Transportation

Skin condition

Ulcers present *
☐**Yes**
☐**No**
If yes complete description and **Braden** staging grade:

Description

Size | **Location**

Improving? ☐ **Yes** ☐ **No**

Other skin condition (list)

Bladder management*
☐ Indwelling catheter
☐Condom catheter
☐Using incontinent product
☐Toileting required
☐Occasional incontinence
☐Total incontinence

Provide details on relevant treatment, procedures and/or precautions

Bowel management*
☐Continent
☐Toileting required
☐Occasional incontinence
☐Total incontinence
☐Using incontinent product

Provide details on relevant treatment, procedures and/or precautions

Ostomy
☐**Yes** ☐**No**

Type and care/products required

Ability to care for ostomy: ☐ **Independent** ☐ **Total care** ☐ **Requires supervision** ☐ **Requires assistance**

Describe nursing care plan required for ostomy

Completed by:

Date:

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

ALPHAFIM® INSTRUMENT

Toronto Stroke Networks

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

Patient's Name	**DOB** YYYY-MM-DD
Tester Name	**Date of Assessment** YYYY-MM-DD

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		**Note: leave no blanks Enter 1 if not able to test an item due to risk**
Grooming		Walk		**No HELPER** 7. Complete Independence (no device, timely, safely) 6. Modified Independence (device, not timely, or not safely)
Bowel Management		Bowel Management		**Helper** ***Modified Dependence (performs 50% or more of task)*** 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) ***Complete Dependence (performs less than 50% of task)*** 2. Maximal Assistance (patient performs 25% - 49% of the effort) 1. Total Assistance (patient performs < 25% of the effort)
Transfers: Toilet		Transfers: Toilet		
Expression		Expression		
Memory		Memory		
Comments:				

Projected Scores from AlphaFIM® Instrument software at 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	Projected scores are calculated using the AlphaFIM® Instrument software.
FIM® 5 Raw Cognition	
FIM® 13 Rasch Motor	
FIM® 5 Rasch Cognition	
FIM® Motor Range	
FIM® Cognition Range	
FIM® Walking Range	
Help Needed	

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

ORPINGTON PROGNOSTIC SCALE

Toronto Stroke Networks

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

PT/OT to complete

Orpington Prognostic Scale: **Grade the patient by CIRCLING the appropriate scores below.**

Motor deficit in arm Lying supine, patient flexes shoulder to 90 degrees and is given resistance	
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
Proprioception (*eyes closed*) Locates affected thumb	
Accurately	0
Slight difficulty	0.4
Finds thumb via arm	0.8
Unable to find thumb	1.2
Balance	
Walks 10 feet without help	0
Maintains standing position	0.4
Maintains sitting position	0.8
No sitting balance	1.2
Cognition (Hodgkins Mental test): Can the patient recall……. Hodgkins Mental Test score: options are 0.0, 0.4, 0.8, 1.2	
1. Age of the patient	1
2. Time (to the nearest hour)	1
(Prompt by you) I am going to give you an address, please remember it and I will ask you later: 42 West St	
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

Total Orpington Prognostic Score

1.6
+
Motor score
+
Proprioception
+
Balance score
+
Cognition Score

= _____

Interpretation of Stroke Severity Score:

< 3.2 score = **3 minor stroke**
3.2-5.2 score = **1 moderate stroke**
> 5.2 score = **-1 major stroke**

Scoring Cognition (Score out of 10):
Mental score 10 = **0.0**
Mental score 8-9 = **0.4**
Mental score 5-7 = **0.8**
Mental score 0-4 = **1.2**

Strategies for Aphasic Patients

- Provide 3 choices written down if necessary for each question – allow patient to point to answer
- Provide a yes/no answer to a question and provide sufficient time for patient to answer e.g.;
  - Patients age – provide 3 choices and yes/no answer
  - Time – provide 3 choices and yes/no answer or use a clock and allow patient to point

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

ORPINTON PROGNOSTIC SCALE

Toronto Stroke Networks

Patient's Name:			
PT/OT to complete		**Tester Name:**	**Date:**
Stroke Modifiers	**-1** ☐	Coma at onset of stroke	
	+1 ☐	Pure motor deficit	
	-1 ☐	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 ☐	Lacunar infarct	**Parietal symptoms may include:** • **Anosognosia:** ignorance or lack of awareness of deficit • **Finger Agnosia:** inability to name individual fingers such as the thumb or finger • **Right-to-left Confusion:** inability to tell whether the hand, foot or arm of the examiner is on the right or left side of the body • **Aculculia:** impairment of simple arithmetic • **Agraphia:** impairment of ability to write
	-2 ☐	Bihemispheric deficit	
	-1 ☐	Dysphagia	
	-2 ☐	Parietal Symptoms	
	-1 ☐	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?
Patient Modifiers	**+2** ☐	Age <55 years	
	-3 ☐	*Severe cardiovascular disease* CCS Class III-IV and/or NYHA Class III-IV Angina	Confirm the existence of severe cardiac or respiratory disease or symptomatic PVD disease with NP or MD
	-3 ☐	*Severe respiratory disease* Dyspnea Class III-IV	
	-1 ☐	Coexistent symptomatic PVD	
	-1 ☐	Poor premorbid functioning	
Time Modifiers	**+2** ☐	Time elapse since stroke < 2 weeks	
	0 ☐	Time elapsed since stroke = 2-4 weeks	
	-1 ☐	Time elapsed since stroke = 4-8 weeks	
	-2 ☐	Time elapsed since stroke > 8 weeks	
Modified Orpington Score (Sum of modifiers PLUS stroke severity score from previous page) ***If final score is =≥ 0 Client is a candidate for active IP rehab programs or home rehab.*** ***If final score is < 0 Client is a candidate for low tolerance rehabilitation programs***			
If unable to complete the Orpington, Indicate reason		If unable to complete the Orpington indicate reason. Consultation with SLP may be required to complete the Orpington for patients with aphasia	

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE©

Toronto Stroke Networks

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

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

FUNCTIONAL ASSESSMENT

Toronto Stroke Networks

Patient's Name:

PT/OT to complete **Tester Name:** **Date:**

Functional Status* - Comment on current function and patient's PROGRESS (functional gains) since admission and implications for future rehab:

Ability to participate – current status:

Physical Activity tolerance *	**Sitting tolerance ***		**Mental Activity Tolerance ***
☐ 15-30 minutes	☐ **Supported**	☐ **Unsupported**	☐ 15-30 minutes
☐ 30-60 minutes	☐ 15-30 minutes	☐ 15-30 minutes	☐ 30-60 minutes
☐ > 1 hour	☐ 30-60 minutes	☐ 30-60 minutes	☐ >1 hour
	☐ >1 hour	☐ >1 hour	

Frequency of activity/therapy treatment tolerated: ☐ Daily ☐ Multiple times / day ☐ 2-3 x per week ☐ Weekly

Comment on changes or limitations in PARTICIPATION during this admission and implications for future rehab:

Motivation to participate in rehabilitation (choose One)

☐ Demonstrates motivation to participate in rehab (regular attendance and involvement, cooperation)
☐ Usually motivated to participate, occasional frustration apparent
☐ Motivated to participate but attendance, involvement or cooperation irregular

Is the patient experiencing shoulder pain? ☐ **Yes** ☐ **No**

Comment:

Can patient take direction, execute and RETAIN verbal OR written OR visual instructions? ☐ **Yes** ☐ **No**

Anticipated Progress: √ the column matching anticipated independence by end of next rehab setting	**Independent with or without aids**	**Minimal assistance**	**Moderate to maximal assistance**
Locomotion			
Transfers			
ADL			
IADL			
Other (list)			

Additional services:

☐ Pain management
☐ Self-care & mobility assessment prescription

* MANDATORY - Electronic Referral cannot be made without completion of this field

Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

FUNCTIONAL ASSESSMENT – con't

Toronto Stroke Networks

Patient's Name:			
PT/OT to complete	**Tester Name:**	**Date:**	
Visual Perceptual Status – Attention* ☐Normal ☐Mild Inattention ☐Moderate Inattention ☐Severe Inattention		**Visual Perceptual status*** ☐Body neglect ☐Reduced depth perception ☐Affected spatial awareness/skills ☐Apraxia ☐Visual field deficit	
Cognition – Attention* ☐No deficit ☐Mild ☐Moderate ☐Severe ☐Unable to test	**Memory *** ☐No deficit ☐Mild ☐Moderate ☐Severe ☐Unable to test	**Judgment *** ☐No deficit ☐Mild ☐Moderate ☐Severe ☐Unable to test	**Executive Functioning *** ☐No deficit ☐Mild ☐Moderate ☐Severe ☐Unable to test
MoCA Score completed? ☐ Yes ☐ No **If Yes indicate score ___/30**		A score <26 warrants ongoing cognitive assessment	
Comments on COGNITION - Describe Impact of Cognition and Perception on Function <u>during this admission</u>* **If any of mild/moderate/severe checked, mandatory to complete text box**			
In your opinion, rate the patient's progress during this admission ☐Marked progress ☐Moderate progress ☐Minimal progress ☐Patient has plateaued in progress ☐Patient is too acute to measure progress ☐Other (comment)			
Comment, RATE OF PROGRESS			

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Toronto Stroke Rehab Referral System

ACUTE TO INPATIENT REHAB REFERRAL FORM

COMMUNICATION AND SWALLOWING

Toronto Stroke Networks

Patient's Name:

SLP to complete **Tester Name:** **Date:**

Is Speech Language Pathologist involved with this patient ☐ **Yes** ☐ **No**

Communication Disorder	**Speech***	**Communicates**
☐None ☐New ☐Old ☐Both new and old	☐Adequate ☐Receptive aphasia ☐Expressive aphasia ☐Dysarthria ☐Apraxia ☐Cognitive communication deficit ☐Voice disorder	☐Adequately ☐With Difficulty ☐Unable

Current status and changes in COMMUNICATION during this admission

Changes in Communication*

Swallowing Disorder *	**Phase Swallowing Affected**
☐None ☐New ☐Old ☐Both new and old	☐Pharyngeal ☐Oral ☐Both ☐Esophageal

Current status and changes in SWALLOWING during this admission and implications for future rehab:*

Has videofluoroscopy been performed on this admission?	**Repeat/videofluoroscopy recommended?**
☐Yes ☐No	☐Yes ☐No

Diet *	**Adjusted diet: solids**	**Adjusted diet: liquids**
☐Regular ☐NPO ☐NG ☐GJ ☐J ☐G	☐Minced diet ☐Pureed diet ☐Dental soft diet ☐Snacks only ☐Other (list below):	☐Thin liquids ☐Nectar thick liquids ☐Honey thick liquids ☐Pudding ☐Sips of water only ☐G-tube feeds ☐Other (list below):

Changes in DIET during this admission and implications for future rehab

Anticipated Progress: √ the column matching anticipated level of independence by end of next rehab setting	**Independent with or without aids**	**Minimal assistance**	**Moderate to maximal assistance**
Communication			
Feeding			

Impact of communication disorder(s) on behavior

☐None
☐Mild
☐Moderate
☐Severe

Speech, language and diet comments:

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