eStroke Rehab Referral in RM&R

EXTERNAL INPATIENT to OUTPATIENT REHAB REFERRAL FORM

Toronto Stroke Networks

CLIENT DETAILS

Patient's First Name | **Last Name**

Responsible Person *(for purposes of the referral)**

Health Card Number | **Version** | **Expiry Date**

Province/Territory Issuing Health Card | **Referral Provider** (Organization name)

DEMOGRAPHICS

Patient DOB **YYYY-MM-DD**

MRN

Does client have a permanent address?* ☐ Y ☐ N

If NO, indicate living arrangements post discharge _____

If YES, is this the same address the patient will be discharged to? ☐ Y ☐ N

If NO, indicate living arrangements post discharge _____

Patient's Home Address* | **City** | **Province**

Postal Code* | **Home Phone**

Does the patient have an alternate contact?* ☐ Y ☐ N

Alternate Contact Name | **Alternate Contact Phone** | **Relation to patient**

What is primary method to contact patient?* ☐ **Home phone** ☐ **Alternate Phone** ☐ **Other**
If OTHER – *Please specify*

Special considerations when contacting the patient eg aphasia, dysarthria, cognition etc _____

Current Location*:

SUPPLEMENTARY INFORMATION

When was patient admitted to ACUTE care?* **YYYY-MM-DD**

Patient's Gender ☐ M ☐ F ☐ **Other** **Patient's Age:**

Referral Contact*: **Name** **Email address**

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

Primary Care Provider's **Name** **Contact number**

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

Interpreter Needed?* ☐ **Yes** ☐ **No**

Rehab Setting Type*

Select referral type ☐ **HIR** ☐ **LIR** ☐ **Outpatient Rehab**

Select: ☐ **Acute to outpatient** ☐ **Inpatient to outpatient referral (external)**

Apply to 1 outpatient rehab facilities based on closest to home/discharge destination and/or patient preference.

Estimated discharge date* **MM/DD/YYYY** **Estimated date ready to start OP rehab*** **MM/DD/YYYY**

Are there any circumstances that will delay start of OP rehab?*
Is the patient appropriate for virtual assessment and/or treatment?*

When was patient admitted to Rehab? **MM/DD/YYYY**

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REASON FOR REFERRAL

Check ALL that apply*

- ☐ **Dietitian**
- ☐ **Neuropsychology~**
- ☐ **Nursing**
- ☐ **Occupational therapy**
- ☐ **Physiatry**
- ☐ **Physical therapy**
- ☐ **Psychology**
- ☐ **Social work**
- ☐ **Speech language pathology/ Communication**
- ☐ **Speech language pathology/ Swallowing**

☐ **Other rehab services (list)**_____

~Referral will be made internally by the Outpatient team on assessment

Transportation* (check ALL that apply)

- ☐ **Independent**
- ☐ **Accompanied by friend/family**
- ☐ **Accompanied by attendant**
- ☐ **Uses Wheel Trans**
- ☐ **Uses public transport**
- ☐ **Uses other (list)**_____

Additional Referral Comments:

MEDICAL and CARE REQUIREMENTS

DATE OF STROKE ONSET* MM/DD/YYYY

TYPE OF STROKE

PAST MEDICAL HISTORY/ CO-MORBIDITIES*

SPECIAL CONSIDERATIONS* eg surgeries, lifting/ cardiac precautions ☐ Yes ☐ No

If YES, *please specify*

RELEVANT MENTAL HEALTH HISTORY* ☐ Yes ☐ No

If YES, - describe history, current status including suicide risk, provide details of follow-up arrangements:

IF YES - Followed by Assertive Community Treatment (ACT) Team/Case Manager?* ☐ Yes ☐ No

If YES *(mandatory text box)***, Is the ACT/ Case Manager the primary contact for this patient? ☐ Yes ☐ No**

If YES Name phone email

SUBSTANCE ABUSE
Current Substance Abuse:* ☐ Yes ☐ No ☐ Not known

If YES – please specify

HAS THE MINISTRY OF TRANSPORTATION BEEN NOTIFIED OF PATIENT'S MEDICAL STATUS?* ☐ Yes ☐ No

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ALLERGIES IDENTIFIED* ☐ **Yes** ☐ **No**

If YES, "List specific allergies"

BEHAVIOUR ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

If YES ☐ **Wandering** ☐ **Aggressiveness** ☐ **Other**

If Other, please specify

Does the patient pose a safety risk to self?* ☐ **Yes** ☐ **No**

If YES, please specify

Does the patient pose a safety risk to others?* ☐ **Yes** ☐ **No**

If YES, please specify

If YES to either of the 2 questions above - Is there a Safety Plan in place?* ☐ **Yes** ☐ **No**

If YES, please specify details of Safety Plan

SPECIAL CONSIDERATIONS IDENTIFIED?*

Any special considerations to support this patient in an outpatient setting? ☐ **Yes** ☐ **No**

If YES, please specify

PAIN ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

If YES, please specify

Attending Physician*

SWALLOWING AND COMMUNICATION

SWALLOWING ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

If YES, please specify

Goals/Comments

COMMUNICATION ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

IF YES

☐ **Hearing** ☐ **Vision** ☐ **Language, comprehension** ☐ **Language, expression** ☐ **Speech Dysarthria** ☐ **Speech Apraxia** ☐ **Other**

If Other, please specify

Goals/Comments

FUNCTIONAL ASSESSMENT

MOBILITY ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

Ambulation: ☐ **Indep** ☐ **Assist x1** ☐ **Assist x2** ☐ **Supervision** ☐ **Mobility Aid Required?** _____

Transfers: ☐ **Indep** ☐ **Assist x1** ☐ **Assist x2** ☐ **Supervision** ☐ **Transfer Aid Required?** _____

Activity Tolerance: ☐ **<1 hour** ☐ **1-2 hrs** ☐ **2-3 hrs** ☐ **>3hrs**
☐ **Paresis** ☐ **Falls/history of falls** ☐ **Other** ☐ **None**

If Other, please specify

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Goals/Comments

COGNITIVE ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

If YES
☐ **Orientation** ☐ **Attention** ☐ **Concentration** ☐ **Participation** ☐ **Judgment/ Insight** ☐ **Carryover/New Learning**
☐ **Memory** ☐ **Executive Function** ☐ **Frustration tolerance**
☐ **Other** _____

If Other, please specify

Goals/Comments

VISUO PERCEPTUAL ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

If YES
☐ **Inattention** ☐ **Neglect** ☐ **Spatial Awareness** ☐ **Apraxia** ☐ **Other**

If Other, please specify

Goals/Comments

ACTIVITIES OF DAILY LIVING ISSUES IDENTIFIED?* ☐ **Yes** ☐ **No**

If YES
☐ **Self-care** ☐ **Toileting** ☐ **Other**

If Other, please specify

Can caregiver assist with toileting if needed?* ☐ **Yes** ☐ **No**

Goals/Comments

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