Toronto Stroke Networks

Toronto eStroke Rehab RM&R System

ACUTE CARE TO OUTPATIENT 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.

Note: Referrals to community programs require the ATTENDING physician's name and phone number

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

☐ **Outpatient Rehab**

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

Additional Referral Comments

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

Toronto eStroke Rehab RM&R System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM

ACUTE MEDICAL ASSESSMENT

Toronto Stroke Networks

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):

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Toronto eStroke Rehab RM&R System

ACUTE TO OUTPATIENT 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 OUTPATIENT REHAB REFERRAL FORM

SOCIAL INFORMATION

Toronto Stroke Networks

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 OUTPATIENT REHAB REFERRAL FORM

SOCIAL INFORMATION (cont'd)

Toronto Stroke Networks

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 Stroke Rehab Referral System

ACUTE TO OUTPATIENT 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** **No HELPER** 7. Complete Independence (no device, timely, safely) 6. Modified Independence (device, not timely, or not safely) **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)
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 (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 OUTPATIENT 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 OUTPATIENT REHAB REFERRAL FORM

ORPINGTON 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 OUTPATIENT 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 OUTPATIENT 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 *
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ > 1 hour

Sitting tolerance *

☐ **Supported**
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >1 hour

☐ **Unsupported**
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >1 hour

Mental Activity Tolerance *
- ☐ 15-30 minutes
- ☐ 30-60 minutes
- ☐ >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

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Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT 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 OUTPATIENT 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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Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM

COMMUNITY REFERRAL

Note: Only complete this section if the patient is being referred to rehab in the community

Reason for referral – services, programs and transportation (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:

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