Acute Care to Rehab & Complex Continuing Care (CCC) Referral

Hôpital général de la baie Georgienne
GEORGIAN BAY General Hospital

Patient Identification

Referral Destination

☐ *Referral to Rehab: (Please check one)*

☐ HTSD / Regular stream ☐ LTLD/slowstream ☐ Either (Receiving facility to determine)

☐ *Referral to Complex Continuing Care (CCC) (For LTLD / slowstream rehab, select within Rehab Category above)*

If Faxed Include Number of Pages (Including Cover): _____Pages

Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY

Patient Details and Demographics

Health Card #: Version Code: Province Issuing Health Card:

No Health Card #: ☐ No Version Code: ☐

Surname: Given Name(s):

No Known Address: ☐

Home Address: City: Province:

Postal Code: Country: Telephone: Alternate Telephone:
No Alternate Telephone: ☐

Current Place of Residence (Complete If Different From Home Address) :

Date of Birth: DD/MM/YYYY Gender: ☐ M ☐ F ☐ Other_____ Marital Status:

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ Other _____

Primary Alternate Contact Person:

Relationship to Patient (Please Check All Applicable Boxes): ☐ POA ☐ SDM ☐ Spouse ☐ Other_____

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Secondary Alternate Contact Person: None Provided: ☐

Relationship to Patient: ☐ POA ☐ SDM ☐ Spouse ☐ Other _____(Please Check All Applicable Boxes)

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Insurance: N/A: ☐

For CCC Only - Co-Payment Discussed With: ☐ Patient ☐ Other_____

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Rehab/CCC Population Requested:

☐ ABI ☐ Amputee ☐ Burns ☐ Cardiac ☐ Chronic Ventilation ☐ General/Medical

☐ Geriatric ☐ MSK ☐ Neuro ☐ Oncology ☐ Respiratory Rehab ☐ Spinal Cord

☐ Stroke ☐ Trauma ☐ Transplant ☐ Other _____

Current Location Name: Current Location Address: City:

Province: Postal Code:

Current Location Contact Number: Bed Offer Contact Name: Bed Offer Contact Number:

Medical Information

Primary Health Care Provider (e.g. MD or NP) Surname: Given Name(s):

☐ None

Allergies: ☐ No Known Allergies ☐ Yes --- If Yes, List Allergies:

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify):_____

Admission Date: DD/MM/YYYY Date of Injury/Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Nature/Type of Injury/Event:

Primary Diagnosis:

Current Medical Issues:

Past Medical History:

Height: Weight:

Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No

☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____ Location: _____

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Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No

Frequency: _____ Duration: _____ Location: _____

Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No

Frequency: _____ Duration: _____ Location: _____

Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ No Details:

Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative; Palliative Performance Scale: _____ ☐ Unknown

Advanced Medical Directives:

Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other _____

Pending Investigations: ☐ Yes ☐ No Details:

Frequency of Lab Tests: _____ Unknown: ☐ None: ☐

Study Medications: ☐ Yes ☐ No Details:

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements ?: ☐ Yes ☐ No -- If No, Skip to Next Section

Supplemental Oxygen: ☐ Yes ☐ No Ventilator: ☐ Yes ☐ No

Special Oxygen Equipment/Human Resources required? (e.g. rebreather, Optiflow, specialized resources of Respiratory Therapist):

☐ No ☐ Yes (if Yes, Please Specify):

Breath Stacking: ☐ Yes ☐ No Insufflation/Exsufflation: ☐ Yes ☐ No

Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless Type: Size:

Suctioning: ☐ Yes ☐ No Frequency:

C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

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Additional Comments:

IV Therapy

IV in Use?: ☐ Yes ☐ No -- If No, Skip to Next Section

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

Name of IV Medication:

Swallowing and Nutrition

Swallowing Deficit: ☐ Yes ☐ No Swallowing Assessment Completed: ☐ Yes ☐ No

Type of Swallowing Deficit Including any Additional Details:

TPN: ☐ Yes (If Yes, Include Prescription With Referral) ☐ No

Enteral Feeding: ☐ Yes ☐ No ☐ Tube Type: _____ ☐ Specify Formula Type & Rate of Feeds: _____

Skin Condition

Surgical Wounds and/or Other Wounds/Ulcers: ☐ Yes ☐ No -- If No, Skip to Next Section

1. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

2. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

3. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

* ***If additional wounds exist, add supplementary information on a separate sheet of paper.***

Continence

Is Patient Continent?: ☐ Yes ☐ No -- If Yes, Skip to Next Section

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Bladder Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Pain Care Requirements

Does the Patient Have a Pain Management Strategy?: ☐ Yes ☐ No -- If No, Skip to Next Section

Controlled With Oral Analgesics:	☐ Yes	☐ No
Medication Pump:	☐ Yes	☐ No
Methadone:	☐ Yes	☐ No
Epidural:	☐ Yes	☐ No
Has a Pain Plan of Care Been Started:	☐ Yes	☐ No

Communication

Does the Patient Have a Communication Impairment?: ☐ Yes ☐ No --If No, Skip to Next Section

Communication Impairment Description:

Cognition

Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess -- If No or Unable to Assess, Skip to Next Section

Details on Cognitive Deficits:

Has the Patient Shown the Ability to Learn and Retain Information: ☐ Yes ☐ No -- If No, Details: _____

Delirium: ☐ Yes ☐ No -- If Yes, Cause/Details: _____

History of Diagnosed Dementia: ☐ Yes ☐ No

Behaviour

Are There Behavioural Issues?: ☐ Yes ☐ No -- If No, Skip to Next Section

Does the Patient Have a Behaviour Management Strategy: ☐ Yes ☐ No

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering
☐ Sundowning ☐ Exit-Seeking ☐ Resisting Care ☐ Other
☐ Restraints -- If Yes, Type/Frequency Details : _____

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Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one

Social History

Discharge Destination: ☐ Multi-Storey ☐ Bungalow ☐ Apartment ☐ LTC

☐ Retirement Home (Name):

Accommodation Barriers: ☐ Unknown

Smoking: ☐ Yes ☐ No Details:

Alcohol and/or Drug Use: ☐ Yes ☐ No Details:

Previous Community Supports: ☐ Yes ☐ No Details:

Discharge Planning Post Hospitalization Addressed: ☐ Yes ☐ No Details:

Discharge Plan Discussed With Patient/SDM: ☐ Yes ☐ No

Current Functional Status

Patient Goals (Please Indicate Specific, Measurable Goals)

Sitting Tolerance: ☐ More Than 2 Hours Daily ☐ 1-2 Hours Daily ☐ Less Than 1 Hour Daily ☐ Has not Been Up

Transfers: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Mechanical Lift

Ambulation: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Unable

Number of Metres: _____

Stairs: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Stair Lift/Glider

Weight Bearing Status:

Left: ☐ U/E ☐ L/E

☐ Full ☐ As Tolerated ☐ Partial _____% ☐ Toe Touch ☐ Non Date expected to be weight-bearing _____ DD/MM/YYYY

Right: ☐ U/E ☐ L/E

☐ Full ☐ As Tolerated ☐ Partial _____% ☐ Toe Touch ☐ Non Date expected to be weight-bearing _____ DD/MM/YYYY

Limbs:

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

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

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Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2

Activities of Daily Living

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

Current Status – Complete the Table Below:

Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Eating: (Ability to feed self)						
Grooming: (Ability to wash face/hands, comb hair, brush teeth)						
Dressing: (Upper body)						
Dressing: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						

Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No -- If No, Skip to Next Section

☐ HALO ☐ Orthosis (including splints, slings)

☐ Bariatric - If Yes, Please Describe Equipment Needs:_____

☐ Other:

Pleuracentesis: ☐ Yes ☐ No Drain: ☐ Yes ☐ No - If Yes, Type Details:_____

Paracentesis: ☐ Yes ☐ No Drain: ☐ Yes ☐ No - If Yes, Type Details:_____

Need for a Specialized Mattress: ☐ Yes ☐ No Negative Pressure Wound Therapy (NPWT): ☐ Yes ☐ No

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Rehab Specific
AlphaFIM® Instrument

Is AlphaFIM® Data Available: ☐ Yes ☐ No -- If No, Skip to Next Section

Has the Patient Been Observed Walking 150 Feet or More: ☐ Yes ☐ No

If Yes –Raw Ratings (rate levels 1-7):	Transfer: Bed, Chair_____	Expression_____	Transfers: Toilet_____
	Bowel Management_____	Locomotion: Walk_____	Memory_____
If No – Raw Ratings (rate levels 1-7):	Eating_____	Expression_____	Transfers :Toilet_____
	Bowel Management_____	Grooming_____	Memory_____
Projected:	FIM® projected Raw Motor (13):	FIM® projected Cognitive (5):	
	Help Needed:		

Attachments

Details on Other Relevant Information That Would Assist With This Referral:

Please Include With This Referral:

- ☐ Admission History and Physical
- ☐ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician)
- ☐ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.)
- ☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)

Completed By: **Title:** **Date:** DD/MM/YYYY

Contact Number: **Direct Unit Phone Number:**

NSM Regional CCC Program Letter of Understanding

CLIENT IDENTIFICATION - Please Print

Name: _____ HCN: _____ Ver_____
Surname Given

We hope that you and your family members have had a positive experience during your stay in hospital. We are pleased to tell you that you no longer need to receive care within acute care. We have talked about discharge options and, in consultation with you and your family, it has been decided your needs may be best met at another facility (complex continuing care or CCC).

To ensure this transition is simple and your needs are our top priority, a referral will be made by your care team to the Regional Complex Continuing Care (CCC) Program. If you (or a family member) are eligible for this program, your name will be added to the waiting list for a CCC bed in any one of the following two North Simcoe Muskoka sites:

- Georgian Bay General Hospital - Midland
- Muskoka Algonquin Healthcare – Bracebridge

When a bed becomes available in one of these two sites and you (or your family member) are the next person on the waiting list, your personal and medical information necessary for admission to the Regional Complex Continuing Care Program will be sent to the CCC program for their review. You will then be notified that the bed is available and the hospital will help you transfer to the site where the bed is located.

Once admitted to CCC, your care team will continue to assess your progress and help you make plans to eventually return home.

While in the program, you are encouraged to participate in therapy and programs which will help you meet your rehabilitation goals. If you do not wish to participate in therapy, your (or your family member's) treatment plan may be re-evaluated and enrollment in the CCC program reviewed.

You may be required to rent mobility aids (e.g. wheelchair, walker, etc.) during your stay if advised. A co-payment may apply depending on the program type that you enter into or re-designated to during your stay , for more information please speak with your care team.

Once you have completed the CCC program, you **may be** discharged or transferred back to your local community hospital as you wait to go to your discharge destination (home, long-term care, with family). You will be discharged when your goals have been met or if a plateau in your progress occurs.

Client /SDM Signature: _____ **Date:** _____

Relationship to Client: _____

Verbal agreement:

From: _____ **Relationship to Client:** _____

Hospital Staff: _____ **Date:** _____