Holland Bloorview
Kids Rehabilitation Hospital
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HANDOVER TOOL

FOR INPATIENT and DAYPATIENT

To be completed in pen by a health care professional 48 **HOURS prior to patient transfer. Please print legibly.**

Date completed: _____ **Date of admission to HBKRH:**_____

NAME OF CLIENT:

_____	_____	_____	_____
Surname	Given	Initial	Preferred Name/Nickname

☐ **Brain Injury Rehab Team** ☐ **Specialized Orthopaedic Developmental Rehab** ☐ **Complex Continuing Care**

A. MEDICAL HISTORY/PHYSICIAN SECTION

HOSPITAL COURSE (updates since initial referral):

Please complete box below *only* if patient has any physician ordered mobility restrictions and/or wound care:

☐ **Had orthopaedic surgery with pre-booked Bloorview bed –** Ensure 1 page post-op d/c order form has been completed

☐ **Other –Physician to complete rehab orders below and sign:**

Weight Bearing Status: ☐ RIGHT Upper/Lower Extremity ☐ LEFT Upper/Lower extremity
☐ Non WB ☐ Touch WB ☐ Partial WB ☐WB as tolerated **Duration** of WB restriction:_____ x weeks

Activity Restrictions:
ROM as tolerated: ☐yes ☐no *precautions:*_____
Active ROM: ☐yes ☐no *precautions:*_____
Passive ROM: ☐yes ☐no *precautions:*_____
Strengthening/Resistance training permitted: ☐yes ☐no *precautions:*_____

Please indicate any other precautions/contraindications to therapy or patient care:
_____

Orthoses/Bracing/Stockings/Garments*:*
☐Neck ☐Trunk ☐Upper extremity: L or R ☐Lower extremity: L or R
Specify type (TLSO, Jewitt, AFO, *etc*.): _____

Wear Recommendations: ☐wear at all times ☐wear when upright ☐off in bed (HOB angle below_____)
☐Wear for any weight bearing/mobilizing ☐Wear for transportation only
☐Other wear recommendations: _____

Recommended interventions (i.e. hydrotherapy, traction, splinting *etc*): _____
_____

Wound Care: ☐ Required ☐ Not required
*Dressing Materials/Type:*_____*Dressing Frequency:*_____

Physician Signature: _____ **Date:** _____

REF INPATIENT

FOLLOW-UP PLANS: complete below OR see attached ☐

Follow up Blood work required: ☐Yes ☐ No Schedule: _____
Radiation and/or Chemotherapy Schedule: _____
_____

FOLLOW-UP CLINICS BOOKED:
Name:_____ Time:_____ Tel:_____ext_____
Name:_____ Time:_____ Tel:_____ext_____
Name:_____ Time:_____ Tel:_____ext_____

MEDICAL/SURGICAL FOLLOW-UP PLAN
Staff Person:_____ Follow-up Clinic:_____ Date: _____
Staff Person:_____ Follow-up Clinic:_____ Date: _____
Staff Person:_____ Follow-up Clinic:_____ Date: _____
Future Surgery:_____ Date: _____
Future Imaging: _____ Date: _____

B. NURSING SECTION

Allergies *(drug, food, latex, etc.)* _____

Medications ☐ See attached Medication Profile (or complete below)

CURRENT MEDICATIONS State medication, dose and helpful hints. Highlight unusual medications e.g. chemo.

Drug	Dose	Frequency	Route	Length of Rx

DOES THE FAMILY HAVE HEALTH BENEFITS: ☐ Yes ☐ No ☐ Unsure

SECTION 8 REQUIRED: ☐ Yes ☐ No Application Completed: ☐ Yes ☐ No

Immunizations Up to Date: ☐ Yes ☐ No Had Chicken Pox: ☐ Yes ☐ N ☐ Vaccination

Current season's influenza vaccine ☐ Yes ☐ No Contraindicated (state reason): _____

Isolation Precautions: ☐ Yes ☐ No Explain**:** _____

PAIN MANAGEMENT
Pain Medications:_____ Adjuncts: (i.e. Advil, Valium)_____

Frequency of administration in last 24-48hours:_____Pain Assessment Tool:_____

Non-pharmacological/distraction techniques:_____

Any aggravating factors:_____

MOST current lab reports *(Blood, X-ray, i.e. MRI, CT Scan e.g.)* **Attached** ☐
Skin Integrity/Breakdown/Pressure Ulcer
Location: _____

Wound Care/ Dressings
Location: _____
Instructions for Care: _____
_____

MEDICAL ASSISTIVE TECHNOLOGY
Any Changes: ☐ Yes ☐ No Describe: _____
Describe any other Supplies/Equipment required: _____

SEIZURE ACTIVITY ☐ Yes ☐ No
Describe: _____

GLASGOW COMA SCALE: ___/15

SENSORY
Vision
☐ Adequate ☐ Impaired *Describe:* _____ Glasses Yes ☐ No ☐
Comments: (*e.g., blurry vision, eye patch*) _____

Hearing- (with aid, if worn)
☐ Adequate ☐ Impaired ☐ Deaf ☐ Hearing Aid

Level of consciousness
☐ Alert ☐ Lethargic ☐ Comatose
Comments*: (e.g. reduced endurance, ability to attend)*
_____

FAMILY EDUCATION: What is the family doing with the child now?
☐ PROM/ Stretching ☐ Exercises ☐ Walking ☐ Transfers ☐ Home/Ward programs
☐ Feeding ☐ CPR ☐ Seizure management ☐ Other Program _____

C. NURSING/NUTRITION/OCCUPATIONAL THERAPY SECTION

ACTIVITIES OF DAILY LIVING
Sleep
☐ Sleeps most of the night ☐ Awakens frequently ☐ Naps required
☐ Speciality mattress required: ☐ Yes ☐ No Type: _____
☐ Type of bed _____ ☐ Sleep Position _____
☐ Rail padding/ positional devices Comments: _____

Ability to dress
☐ Independent ☐ Needs Supervision ☐ Needs Assistance ☐ Dependent
Comment: _____

Hygiene
☐ Independent ☐ Needs Supervision ☐ Needs Assistance ☐ Dependent
☐ Shower bench/commode
Comment: _____

ELIMINATION

Bowel
☐ Full Control ☐ Bowel Routine *(to maintain control)* ☐ Occasional incontinence
☐ Incontinent ☐ Toilet training ☐ Commode Type

Bladder
☐ Full Control ☐ Bladder Routine (to maintain control) ☐ Occasional incontinence
☐ Incontinent Diaper size_____ ☐ Drainage Condom ☐ Catheter
Catheter routine (times): _____ Catheter type/size: _____

NUTRITION

Anthropometric History:
Weight History: _____
Height/Lenght: _____
Other Pertinent information: _____

Oral Feeding : ☐ Yes ☐ No Gag Reflex: ☐ Yes ☐ No
☐ NPO ☐ Difficulty chewing ☐ Difficulty swallowing
☐ Breastfed ☐ Bottle fed – feeding schedule: _____

Consistency of food
☐ Not safe for solids ☐ Pureed ☐ Minced/Ground ☐ Soft diet ☐ Regular
☐ Special Diet (*kosher, calorie reduced, etc.)*
Comment _____

Consistency of fluids
☐ Not safe for liquids ☐ thin liquid ☐ nectar ☐ honey ☐ regular
☐ Thin puree ☐ pudding

Alternative feed method
☐ Gastrostomy (G) Tube ☐ G/J tube ☐ Pump ☐ Gravity
☐ Nasogastric (NG) tube ☐ Total Parenteral Nutrition
Tube size/type: _____ Formula: _____
Volume of feed: _____ Rate of Feed: _____
Feeding schedule: _____

Video fluoroscopic feeding study completed? ☐ Yes ☐ No Please attach report or provide the date: _____
Findings _____
Future study: _____ Future surgery: _____

Current Feeding Recommendations: _____

D. REHAB SECTION/OCCUPATIONAL & PHYSIOTHERAPY

Mobility
☐ Bed rest ☐ Sits (with, without) assistance at edge of bed
☐ Walks with assistance X (___) persons or with (_____) describe aid
☐ Walks with close supervision ☐ Walks Independently

Transfers:
☐ Independent ☐ Requires supervision
☐ Requires assistance of ____ number of persons ☐ Min ☐ Mod ☐ Max (lift)

Aids/Seating
☐ Manual Wheelchair ☐ Power W/C
Wheelchair type _____ dimensions/size _____
Cushion: _____
☐ Stroller Type _____ ☐ Walker Type _____
☐ Splints ☐ Casts ☐ Collar ☐ Halo ☐ Other _____

SAFETY/SUPERVISION

Behaviour/coping patterns
☐ Co-operative ☐ Withdrawn
☐ Agitated ☐ Night time ☐ Daytime
☐ Aggressive ☐ Verbally ☐ Physically
☐ Triggers: ☐ Noise ☐ Light ☐ Frustration ☐ Pain
☐ Wanderer
Comments: _____

ANY RESTRICTIONS
Specify: _____
☐ 1:1 Supervision Required
☐ Physical restraints _____
☐ Helmet – Wearing Schedule: _____

RANCHOS CURRENT LEVEL: ***Circle*** **1 2 3 4 5 6 7 8**

Current Therapy Recommendations: _____

E. SPEECH LANGUAGE PATHOLOGY SECTION

COMMUNICATION

Expressive Speech
☐ Functional ☐ Impaired: ☐ Mild ☐ Moderate ☐ Severe ☐ Sound Speech production
☐ Alternative and Augmentative Communication Utilized
Comments*: (e.g. thumbs up, down, word finding: slurred speech: higher lever language difficulties)*

Comprehension
☐ Normal ☐ Impaired ☐ Mild ☐ Moderate ☐ Severe
Comments: (*e.g.; difficultly following 1-2 step verbal commands; difficulty understanding complex language*)

Current SLP Recommendations:

F. SOCIAL WORK SECTION

SPECIAL PSYCHOSOCIAL ISSUES

☐ **SCAN Involvement** **CAS Contact:**

Current Emotional State:

Any recent losses in family: ☐ Yes ☐ No

Plans for ongoing therapy or follow-up: ☐ Yes ☐ No

Community Referrals made (e.g. CCAC, OACRS, etc): ☐ Yes ☐ No

Assistance for Children with Severe Disability Application: ☐ Yes ☐ No

Special Services at Home Application: ☐ Yes ☐ No

Additional Comments: See attached ☐

G. Family Psychiatric History Section

Has anyone in the family been diagnosed with a psychiatric issue: ☐ Yes ☐ No Who?

If so are they currently involved in therapy: ☐ Yes ☐ No Name of therapist:

Plans to continue:

H. DEMOGRAPHICS

No change from initial referral ☐

LEGAL GUARDIAN	Legal Guardian: Name: _____ Address: _____ _____ Home (H) _____ (W) _____	In Case of an Emergency Contact: Name: _____ _____ Relationship:_____ _ Home(H) _____(W)_____ __

Hospital Contacts:

Staff Physician:
Name:_____
Tel: _____ ext _____

PT:
Name:_____
Tel: _____ ext _____

OT
Name:_____
Tel: _____ ext _____

Discharge Planners/TCC
Name:_____
Tel: _____ ext _____

Dietician
Name:_____
Tel: _____ ext _____

SW
Name:_____
Tel: _____ ext _____

SLP
Name:_____
Tel: _____ ext _____

Unit/Nurse Practitioner
Name:_____
Tel: _____ ext _____

SCHOOL INFORMATION
Home School Name: _____Grade:_____
School address:_____
Telephone Number:_____Teacher's Name: _____
School aware: ☐ Yes ☐ No School involved: ☐ Yes ☐ No

Community Vendors (including SickKids): _____
_____
Contact Name (*and telephone*): _____

IF DISCHARGED HOME BEFORE TRANSFER TO BLOORVIEW KIDS REHAB – FILL OUT THIS SECTION:

CCAC Case Manager:
Name:_____

Priority Interim ☐ Yes ☐ No
Tel: _____ ext _____

CCAC Involvement – please describe what services have been put in place: _____
_____
_____
_____

IF MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Insurance Company Name: _____ Telephone: _____
Case Manager's Name/Company: _____ Telephone: _____
Lawyer's Name/Firm: _____ Telephone: _____