

REFERRAL FORM: REHABILITATION, COMPLEX CONTINUING CARE & RESPITE

To be completed in pen by a health care professional or family member. Please print legibly.

Name of Client:

Surname _____ Given _____ Initial _____ Preferred Name/Nickname _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Surgical Interventions: _____

Reason for Admission: _____

Requested Admission Dates: _____

FOR OFFICE USE ONLY:			
<input type="checkbox"/> Respite	<input type="checkbox"/> BIRT	<input type="checkbox"/> SODR	<input type="checkbox"/> Complex Continuing Care

PERSONAL			
DEMOGRAPHICS [] see attached	<input type="checkbox"/> Male <input type="checkbox"/> Female Birth Date Y M D Age: _____	Religion/Culture/Traditions: _____	
	Overnight Hospital Admissions within the last 6 months ? Yes <input type="checkbox"/> No <input type="checkbox"/> Immunizations Up to Date: Yes <input type="checkbox"/> No <input type="checkbox"/> Had Chicken Pox: Yes <input type="checkbox"/> No <input type="checkbox"/>		
LANGUAGES / INTERPRETER [] see attached	Languages spoken/understood by child 1. _____ 2. _____		Languages spoken/understood by family: 1. _____ 2. _____
	Interpreter required for child: Yes <input type="checkbox"/> No <input type="checkbox"/>		Interpreter required for family: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Interpreter's Name & Phone Number: _____		
PARENTS INFORMATION [] see attached	Mother's Name _____ Address _____ _____ Home(H) _____ (W) _____		Father's Name _____ _____ _____ H) _____ (W) _____
	Legal Guardian: Guardian's Name: _____ Address: _____ _____ Home(H) _____ (W) _____		In Case of an Emergency: Contact's Name: _____ Relationship: _____ Address: _____ _____ Home(H) _____ (W) _____
PRIMARY PHYSICIAN	Name: _____ Phone #: _____		
	Address: _____		
HEALTH CARD & INSURANCE INFORMATION	Health card number: _____		Other Health Insurance Information: (Name, Group Number, Policy Number)
	If Motor Vehicle Accident, please complete the following information:		
	Insurance Company Name: _____ Telephone: _____		Case Manager's Name/Company : _____ Telephone: _____
Lawyer's Name/Firm: _____ Telephone: _____			

HEALTH HISTORY

BRIEF MEDICAL HISTORY:	
	<input type="checkbox"/> see attached
MEDICATIONS (oral, feeding tube, topical, inhalation, etc.) State medication, times and methods of administration, dose and helpful hints. Remind family to bring in meds in original containers.	<input type="checkbox"/> see attached
ALLERGIES (drug, food [i.e., peanuts], latex, etc.)	
ROUTINES / PROCEDURES /TREATMENTS (e.g., dressings, etc.)	
RECENT LAB REPORTS (Blood, X-ray, i.e. MRI, CT Scan e.g)	<input type="checkbox"/> ATTACH COPIES
SPECIAL PSYCHOSOCIAL ISSUES	
WHAT IS THE FAMILY'S UNDERSTANDING OF THE DIAGNOSIS/PROGNOSIS?	
WHAT IS THE DISCHARGE PLAN?	
OTHER?	

01. MOBILITY

- Immobile Bed rest
- Walks with assistance Walks Independently

AIDS/SEATING

- Manual W/C Electric W/C
- Stroller Insert type _____
- Walker
- Other _____

BRACES/PROSTHESIS

Type _____

TRANSFERS

- Independent Requires supervision
- Requires assistance One person
- Two person More than two or lifting aid

02. SAFETY

- Type of bed _____
- Bed rails
- Rail padding _____
- Physical restraints
- Climbs out of bed Dome over bed
- Helmet Anti tip bars and belt on Wheelchair
- Other _____

Specify: _____

03. NUTRITION

- Breastfed Bottle fed
- Difficulty chewing Difficulty swallowing
- Gag reflex present Yes No
- Consistency of food
 - Pureed Ground Regular
- Gastrostomy (G) Tube G/J tube
- Nasogastric (NG) tube
 - Tube size/type _____
- Total Parenteral Nutrition

Type & amount of feeding/formula: _____

Likes/dislikes: _____

Other (e.g. cultural/religious diet implications): _____

COMMENTS: _____

04. ELIMINATION

BOWEL

- Full control
- Bowel routine (to maintain control)
- Occasionally incontinent
- Incontinent Toilet training
- Commode
- Type/size of diaper _____

Comments: _____

BLADDER

- Full control
- Bladder routine (to maintain control)
- Occasionally incontinent
- Incontinent
- Catheter routine (times) _____

Type/size _____

Drainage condom

Comments: _____

05. SENSORY

VISION

- Adequate Impaired Blind

Glasses Yes No

Prosthesis

HEARING - (with aid, if worn)

- Adequate Impaired Deaf

Device type _____

06. LEVEL OF CONSCIOUSNESS

- Alert Lethargic
- Semi-comatose Comatose

GCS: _____

07. LEVEL OF UNDERSTANDING

- Normal
- Delayed: Mild Moderate Severe

Comments: _____

RANCHOS CURRENT LEVEL: _____

08. ACTIVITIES OF DAILY LIVING -

ABILITY TO DRESS

- Independent Requires supervision
- Requires assistance/aids Dependent

Comments: _____

HYGIENE

- Independent Dependent
- Requires supervision Requires assistance/aids

Comments: _____

SLEEP

Sleeps most of the night Awakens frequently
 Night care routines Describe: _____

Daytime naps Yes No

Comments: _____

09. BEHAVIOUR/COPING PATTERNS

Co-operative Withdrawn
 Agitated: Nighttime Daytime
 Aggressive: Verbally Physically
 Wanderer
 Triggers: Noise Light Frustration

Comments: _____

CONCENTRATION/ATTENTION SPAN

Normal Impaired
 Requires 1:1 supervision
 Close observation Normal observation

Reason/Comments: _____

10. COMMUNICATION

SPEECH

Able to state needs Communicates with difficulty
 Unable to communicate
 Communication devices utilized

Describe: _____

11. SEIZURE ACTIVITY

Yes No

Describe frequency, type, triggers

16. RELIGIOUS/CULTURAL TRADITIONS

Does your child have any cultural and/or religious customs that they will observe during their stay? _____

12. SKIN CONDITION

Normal Wound/Incision(s)
 Burn Stoma Care Other

Describe: _____

13. SPECIAL NEEDS

Suction Oxygen
 Ventilator: Nighttime Only 24 Hours
 Tracheostomy Peripheral IV
 Central Venous Line Internal External
 Dialysis Monitor

Describe any other Supplies/Equipment required: _____

14. SCHOOL

Home School Name: _____

School address: _____

Telephone Number: _____

Teachers Name: _____

Grade : _____

15. COMMUNITY /HOSPITAL RESOURCES INVOLVED

Please Specify:

Signature of Person Completing Form: _____	Date: _____
Referring Source: _____	
Signature of Nurse Reviewing Form on Admission: _____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

If assistance is required in completing this form, please contact the Intake/Discharge Co-ordinator at (416) 753-6030.