

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 & NOTIFY IN EMERGENCY [] see attached | 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.

