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: __________________________
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)

<table>
<thead>
<tr>
<th>CURRENT MEDICATIONS</th>
<th>State medication, dose and helpful hints. Highlight unusual medications e.g. chemo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td>Dose</td>
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</tbody>
</table>

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
□ Specialty 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 / Length: ____________________________
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.; difficulty 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:

__________________________________________________________________________________________
<table>
<thead>
<tr>
<th>DEMOGRAPHICS</th>
<th>No change from initial referral □</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEGAL GUARDIAN</td>
<td>Legal Guardian: ____________________</td>
</tr>
<tr>
<td></td>
<td>Name: _____________________________</td>
</tr>
<tr>
<td></td>
<td>Address: ___________________________</td>
</tr>
<tr>
<td></td>
<td>Home (H) ________ (W) ___________</td>
</tr>
<tr>
<td></td>
<td>In Case of an Emergency Contact:</td>
</tr>
<tr>
<td></td>
<td>Name: _____________________________</td>
</tr>
<tr>
<td></td>
<td>Relationship: ______________________</td>
</tr>
<tr>
<td></td>
<td>Home(H) <strong><strong><strong><strong><strong>(W)</strong></strong></strong></strong></strong></td>
</tr>
</tbody>
</table>

**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:** ___________________________
- **Tel:** __________ ext __________

**Priority Interim**
- □ Yes □ No

**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:** ___________________________