Perth and Smiths Falls District Hospital

Attach Label or fill out

Name: ____________________________
Hospital Number: __________________
Phone Number: ____________________

PSFDH GENERAL INPATIENT REHABILITATION PROGRAM REFERRAL FORM

Admission Criteria:

1. Medically stable
2. Require at least two allied health services
3. Must be able to tolerate a minimum of two 30 min therapy sessions daily
4. Cognitive capacity to be able to follow simple commands, demonstrate ability to learn, demonstrate carry over day to day
5. Patient in agreement to participate in the rehab program: i.e.: motivation to improve
6. Must have guarantee that patient will be repatriated to home hospital if not able to participate in rehab (e.g.: becomes medically unstable, plateaus before meeting goals, does not show improvement after 3 week trial, discharge disposition to LTC or unknown)

Eligible Conditions include:

- Stroke
- Other neurological conditions (e.g.: MS, GBS, PD)
- Acute rehab post LE amputation: do not provide inpatient prosthetic training
- MSK: post arthroplasty, trauma, etc.
- Deconditioning
- Patients with TBI and SCI may be considered for admission, depending on complexity of the individuals needs.

REFERRAL INFORMATION
Referral Date
Referral facility and unit
Referring MRP/Contact phone number
Referral form completed by: Contact Number:

PATIENT DEMOGRAPHICS		
Name:		
DOB:	AGE:	GENDER: M/F
Primary Care Provider:		
Home Address:		
Phone Number:	Cell:	Other:
Contact Person/Relationship/phone number:		
SDM (if required):		
Primary language:		

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CLINICAL PROFILE		
Primary Diagnosis:		
Reason for referral:		
History of presenting illness/course in hospital:		
Current Active Medical Issues:		
Past Medical History:		
BASELINE STATUS PRIOR TO ADMISSION		
Independent for ADL's	☐Yes ☐ No	Describe:
Mobility (eg: aids, stairs, orthotics):		
Independent for iADL's	☐Yes ☐ No	Describe
Cognitive Status (eg: Hx of dementia):		
Employed/Retired:		
Active driver's license	☐Yes ☐ No	
Living arrangements (home, RH, LTC):		
Potential caregiver at home:		
Homecare or other services		
CURRENT FUNCTIONAL STATUS		
Impairments/deficits:		
Activity Tolerance:		
Bed Mobility:		
Sitting balance:		
Transfers:		
Ambulation:		
Weight bearing status/#weeks:		
Bladder Continence:		
Bowel Continence:		
Skin Integrity/wounds		
Speech		
Swallow		
ADL's		
iADL's		
Cognition		
Carry over/ability to learn		
Mood		
Behavioral Concerns		
Pain Care requirements		
Has MOT been notified ☐Yes ☐ No		

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ASSESSMENT SCALES COMPLETED/DATE	
Alpha-FIM	
MoCA/mini Cog	
Berg	
PHQ-9/other mood screens	
Visual Perceptual Screens	
Bedside swallow/VFSS	
Other:	
SPECIAL EQUIPMENT NEEDS	
Bariatric (weight>250 lbs.)	☐Yes ☐ No
Mechanical Lift	☐Yes ☐ No
Enteral Feeds (G-tube/NG)	☐Yes ☐ No
Suction	☐Yes ☐ No
Oxygen	☐Yes ☐ No
Foley	☐Yes ☐ No
Pressure Relief Mattress	☐Yes ☐ No
C-PAP	☐Yes ☐ No
Trach	☐Yes ☐ No
Other	
PATIENT/FAMILY GOALS	
Describe:	
READINESS FOR REHAB	
Medically Stable:	☐Yes ☐ No
IPAC Status	
Outstanding medical investigations:	
Outstanding medical/surgical procedures:	
Follow up appointments:	
DISPOSITION	
Tentative/Anticipated destination:	
Referring Facility has agreed to repatriation if required:	☐Yes ☐ No

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Please fax completed form to: Senior Occupational Therapist, PSFDH Fax Number: 613-267-3964

Once the Referral form has been reviewed, the PSFDH Senior Occupational Therapist will reach out to the Referring Facility's Contact Person within 2 days for further discussion.

Senior Occupational Therapist Contact Phone Number: # 613-267-1500 x3033