

Add Patient Label Here

Fax completed form to: 519-742-0635

Number of pages (including cover):

**Acute Care to Rehab & Complex Continuing Care (CCC) Referral**

**Attachment Checklist:**

☐ Reapplication

**Program:**

- ☐ Low Intensity Rehab (GRH, SJHCG)  
☐ General Rehab (CMH, GRH, SJHCG)  
☐ Stroke Rehab (CMH, GRH, SJHCG):  
☐ Ischemic ☐ Hemorrhagic  
☐ Complex Medical Management (GRH, SJHCG)  
☐ Chronic Assisted Ventilator (GRH)

**Please Include Documentation to Support Brief Notes On Application**

- ☐ Demographic Information  
☐ Confirmation patient is WW resident ([Postal Code Lookup](#))\*\*  
\*\*Stroke Patients residing OOR contact Stroke Navigator 519-501-6708  
☐ Letter of Understanding (Consent and Information Letter Provided)  
☐ Relevant Progress Notes from last 7 days (May include OT, PT, SLP, RD, Nursing)  
☐ Medical History/Consult Notes  
☐ Medication Administration (to be sent at Bed Offer)

**Patient Current Location (Hospital, Floor, Room/Bed):**

**Phone Number for Nursing Unit:**

**MEDICAL INFORMATION**

Medically Stable: ☐ Y ☐ N (Medical issues have resolved/stabilized. There is no plan to change active treatment based on an actively changing condition.)

Primary Diagnosis:

Past Medical History:

History of Present Illness/Surgery:

Active Medical Issues:

Rehab Goals Appropriate to Program:

Follow-Up Appointments / Imaging:

**CLINICAL INFORMATION**

**Vital Signs:**

Height:

Code Status:

Febrile in last 72 hours: ☐ Y ☐ N

Weight:

☐ Bariatric \*consider if Special Equipment is needed

**Allergies:**

Other:

☐ No Known Allergies

**Isolation Status:** ☐ Clear ☐ C-Diff ☐ MRSA ☐ VRE

Other:

**COVID Status:**

Date Considered Resolved:

COVID Vaccine Status:

# HOME AND COMMUNITY CARE SUPPORT SERVICES

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<b>Smoking Status:</b>	Smoker:	<input type="checkbox"/> Y <input type="checkbox"/> N
	Currently smoking while in hospital:	<input type="checkbox"/> Y <input type="checkbox"/> N
	Willingness to abstain from smoking for duration of program:	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Hearing Impaired:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Vision Impaired:</b> <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Speech/Communication:</b>	<input type="checkbox"/> Aphasia/Dysarthria	<input type="checkbox"/> Difficulty Communicating <input type="checkbox"/> Unable to Communicate
<input type="checkbox"/> Adequate	Language:	
<b>Nutrition:</b>	<input type="checkbox"/> Diet type:	<input type="checkbox"/> Enteral feeds:
<input type="checkbox"/> Standard Diet	Texture:	<input type="checkbox"/> Dentures
	Fluid Consistency:	<input type="checkbox"/> Swallowing concerns:
<b>Bladder:</b>	<input type="checkbox"/> Routine Toileting	<input type="checkbox"/> Occasionally Incontinent <input type="checkbox"/> Incontinent
<input type="checkbox"/> Full Control	<input type="checkbox"/> Foley Catheter	Change Due:
<b>Bowel:</b>	<input type="checkbox"/> Routine Toileting	<input type="checkbox"/> Occasionally Incontinent <input type="checkbox"/> Incontinent
<input type="checkbox"/> Full Control	Date of last BM:	
<b>Ostomy:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	Specify:
	<input type="checkbox"/> Independent with care	<input type="checkbox"/> Assistance with care <input type="checkbox"/> Total care
<b>IV Therapy:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	
<b>IV Antibiotics:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequency/Duration:
<b>PICC Line:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	Length:
<b>Dialysis:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequency/Duration:
<b>Radiation:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	
<b>Chemotherapy:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequency/Duration:
<b>Skin Condition:</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Incision <input type="checkbox"/> Requires Positioning
<input type="checkbox"/> Normal	<input type="checkbox"/> Open Sores	<input type="checkbox"/> Dressings <input type="checkbox"/> Requires Foot Care
	<input type="checkbox"/> Decubitus Ulcers	<input type="checkbox"/> VAC Dressing <input type="checkbox"/> Burns
Attached supporting document including specific interventions: (e.g. NSWOC note, nursing note, wound care intervention)		
<b>Special Needs:</b>	<input type="checkbox"/> Special Bed:	<input type="checkbox"/> Special Equipment:
<input type="checkbox"/> N/A		
<b>RESPIRATORY CARE REQUIREMENTS</b>		
Supplemental Oxygen	<input type="checkbox"/> Y <input type="checkbox"/> N	Route: Rate: L/Min
Home Oxygen	<input type="checkbox"/> Y <input type="checkbox"/> N	
Insufflation/Exsufflation:	<input type="checkbox"/> Y <input type="checkbox"/> N	Breath Stacking <input type="checkbox"/> Y <input type="checkbox"/> N
Tracheostomy	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Cuffed <input type="checkbox"/> Cuffless
Suctioning	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequency:
CPAP	<input type="checkbox"/> Y <input type="checkbox"/> N	Patient Owned: <input type="checkbox"/> Y <input type="checkbox"/> N
BiPAP	<input type="checkbox"/> Y <input type="checkbox"/> N	Rescue Rate: <input type="checkbox"/> Y <input type="checkbox"/> N Patient Owned: <input type="checkbox"/> Y <input type="checkbox"/> N
Additional Comments:		

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## THERAPY INFORMATION

### Cognition

WNL= Within Normal Limits I= Impaired

	WNL	I	Comments
Cognitive Function			
MoCA Score			
Ability to Learn/Retain Information			

Responsive Behaviours: ☐ Y ☐ N ☐ Aggression (Verbal/Physical)  
☐ Exit seeking/Wandering ☐ Resisting care  
☐ Need for constant observation

### ADL Function

Ind= Independent SU= Setup Only S= Supervision A= Assistance

	Ind	SU	S	A	Comments (Min/Mod/Max A/x1/x2 Baseline)
Feeding					
Grooming					
Dressing					
Toileting					
Bathing					

### Mobility Function

Ind= Independent SU= Setup Only S= Supervision A= Assistance

	Ind	SU	S	A	Comments (Min/Mod/Max A/x1/x2 Baseline)
Supine <=> Sit					
Bed <=> Chair					
Ambulation					
Stairs					

**Falls** ☐ Y ☐ N # in the last 7 days: Bed/Chair Alarm: ☐ Y ☐ N  
**History:** # in the last 30 days: Other:

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Weight Bearing Status:

Current Mobility Aid:

Prior Mobility Aid:

Current Distance Ambulating:

Movement Restrictions/Activity Orders:

Current Equipment Needs:

**DISCHARGE PLAN (FOLLOWING REHABILITATIVE CARE)**

Has the discharge plan been initiated? ☐ Y ☐ N

If yes, discharge to: ☐ Home Independently ☐ Home with Support

Home setup (i.e. multilevel, apartment, etc.):

☐ RH:

☐ LTCH:

Has the home been notified of patient's return? ☐ Y ☐ N

Prior Home Care Supports:

Are discharge concerns anticipated? ☐ Y ☐ N

Describe:

**CONTACT INFORMATION**

Bed Offer Contact Name:

Bed Offer Contact #:

Contributor	Designation	Contact #	Date

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## LETTER OF UNDERSTANDING

(insert patient's name), your current care needs no longer require an acute hospital setting. The health care team has that your needs may be met within the services offered in a rehabilitative care program. These programs are regional programs, offered at multiple sites within Waterloo Wellington:

- |   |   |
|---|---|
| <input type="checkbox"/> General Rehabilitation       | <input type="checkbox"/> Complex Medical Management               |
| <input type="checkbox"/> Stroke Rehabilitation        | <input type="checkbox"/> Chronic Ventilator / Respiratory Program |
| <input type="checkbox"/> Low Intensity Rehabilitation |   |

Site	General Rehab	Stroke Rehab	Low Intensity Rehab	Complex Medical Management	Chronic Ventilator / Respiratory Program
Grand River Hospital - Freeport Health Centre in Kitchener	✓	✓	✓	✓	✓
St. Joseph's Health Centre in Guelph	✓	✓	✓	✓	

Referrals are coordinated by Home and Community Care Support Services Waterloo Wellington. Your health care team will be sharing your medical and personal information with Home Care WW and the rehabilitative care program. Home Care WW will add your name to the waiting list. Your initials and gender will be accessible to Home Care WW's other hospital partners.

You will be notified by your health care team when a bed becomes available for you. The first available bed may be located at any one of the locations listed above. The health care team will assist you to arrange the transfer to the Rehabilitation program.

I have reviewed and understand the above information. I agree to proceed with the rehabilitative care program referral process. I understand that my personal and health information will be shared with Home Care WW and the rehabilitative care sites within the region.

Patient Name:

Patient/Substitute Decision Maker's (SDM) Signature:

Print SDM Name:

Date:

### Verbal/telephone agreement Documentation (if signature not possible)

Consent Obtained From:

Date:

Signature of Staff Member:

Printed Name of Staff Member obtaining consent: