Fax completed form to 519-742-0635

Ontario Health atHome

Patient Name:

HCN:

Attachment Checklist:

- ☐ Demographic Information
- ☐ Letter of Understanding (Consent and Information Letter Provided)
- ☐ Relevant Nursing & Allied Notes from last 7 days, including initial assessment
- ☐ Comprehensive history & physical; relevant specialist consults

Program:

- ☐ Low Intensity Rehab (WRHN @Chicopee, SJHCG)
- ☐ General Rehab (WRHN @Chicopee, SJHCG)
- ☐ Stroke Rehab (WRHN @Chicopee, SJHCG)
  - ☐ Ischemic ☐ Hemorrhagic
- ☐ Patient is part of Bundled Care Program

City where patient lives:

SDM name & Contact Number:

Family Physician:

Weight Bearing Status / Activity restrictions:

Height: **Weight:**

Primary Diagnosis:

History of Present Illness/Surgery:

Follow-Up Appointments/Imaging:

Sending hospital name, present unit and contact info:

ADL Function (B – Baseline, C – Current) Ind = Independent SU = Setup Only S = Supervision A = Assistance (1x, 2x etc.)

	Ind	SU	S	A	Demonstrated Progress	Goals for Discharge
Feeding						
Grooming						
Dressing						
Toileting						
Bathing						

Function (B – Baseline, C – Current) Ind = Independent SU = Setup Only S = Supervision A = Assistance (1x, 2x etc.)

	Ind	SU	S	A	Demonstrated Progress	Goals for Discharge
Bed Mobility						
Bed <~>Chair						
Ambulation						
Stairs						
Equipment needs						
Cognition – current and goals						
Speech and Swallowing						

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CLINICAL INFORMATION

Code Status:

Allergies: ☐ No ☐ Yes: _____

Isolation Status: ☐ Clear

☐ Contact: _____ ☐ Droplet: _____

Responsive Behaviours: ☐ No ☐ Yes (comment)

_____

Bed/Chair Alarm: ☐ No ☐ Yes ☐ Both

Cytotoxic precautions: ☐ No ☐ Yes

Hearing Impaired: ☐ No ☐ Yes Aids:_____

Vision Impaired: ☐ No ☐ Yes Aids:_____

Bladder: ☐ Continent ☐ Incontinent:

Catheter: ☐ No ☐ Yes – Change Due: _____

Bowel: ☐ Continent ☐ Incontinent Last BM: _____

Ostomy: ☐ No ☐ Yes – Level of Independence: _____

Diet & Texture: _____

Fluid consistency:_____

Enteral Feeds: ☐ No ☐ Yes (provide RD note)

IV Therapy: ☐ No ☐ Yes – Dosage: _____

IV Antibiotics: ☐ No ☐ Yes – Dosage: _____

PICC Line: ☐ No ☐ Yes – External Length: _____

PICC Insertion Date: _____

Drain(s) ☐ No ☐ Yes – Details: _____

Skin Condition: ☐ Intact ☐ Wounds – details:

Dialysis: ☐ No ☐ Yes –Type: ☐ Hemo ☐ PD

Dialysis schedule: _____

Chemo/Rad: ☐ No ☐ Yes (if yes, provide schedule)

Supplemental Oxygen: ☐ No ☐ Yes – L/min: _____

Home 02: ☐ No ☐ Yes – L/min: _____

CPAP: ☐ No ☐ Yes – level of independence: _____

If trach in situ, please provide details in attachment

Cough assist or breath stacking required ☐ No ☐ Yes

DISCHARGE PLAN AND ANY SOCIAL CONSIDERATIONS

Pre-admission home setup (e.g. bungalow, 2 steps to enter; lives with spouse):

Anticipated discharge destination:

Previous Supports: ☐ OHaH: _____ Other supports: _____

Anticipated discharge barriers:

CONTACT INFORMATION

Contributor	Designation	Contact #	Date

Ontario Health atHome

Patient Name:

HCN:

LETTER OF UNDERSTANDING

_____ , your current care needs no longer require an acute hospital setting.

The health care team has assessed that your needs may be met within the services offered in a rehabilitation program. These programs are regional, offered at multiple sites within Waterloo Wellington:

☐ General Rehabilitation

☐ Stroke Rehabilitation

☐ Low Intensity Rehabilitation

Site	General Rehab	Stroke Rehab	Low Intensity Rehab
Waterloo Regional Health Network @Chicopee in Kitchener	✓	✓	✓
St. Joseph's Health Centre Guelph	✓	✓	✓

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 accepting rehabilitation program.

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

I have discussed my rehabilitation goals and anticipated discharge destination with my care team and understand the above information. I agree to proceed with the rehabilitative care program referral process.

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: