



# Rehabilitation Integrated Transition Tracking System (RITTS)

## Questions from the RITTS - ABI Rehabilitation Referral

Please note that shaded boxes are mandatory.

|                                |                     |
|--------------------------------|---------------------|
| Patient name                   | Date                |
| Type of rehabilitation service | Sending physician   |
| Receiving facility             | Receiving physician |

What is the primary diagnosis?

What is the secondary diagnosis / are there other Medical Co-Morbidities?

|   |   |   |
|---|---|---|
| <p>What is the major reason for the referral?</p> <p> <input type="checkbox"/> Activities of daily living<br/> <input type="checkbox"/> Behavioral difficulties<br/> <input type="checkbox"/> Cognitive difficulties<br/> <input type="checkbox"/> Communication problems<br/> <input type="checkbox"/> Emotional adjustment </p> | <p> <input type="checkbox"/> Medical consultation<br/> <input type="checkbox"/> Physical rehabilitation<br/> <input type="checkbox"/> Psycho/social issues<br/> <input type="checkbox"/> Other ☞ </p> | <p>If you selected "Other," please specify:</p> |
|---|---|---|

|  |  |
|--|--|
| <p>Is there a history of substance abuse?</p> <p> <input type="checkbox"/> Yes ☞<br/> <input type="checkbox"/> No </p> | <p>If there is a history of substance abuse, please indicate type:</p> |
|--|--|

|  |  |   |
|--|--|---|
| <p>Does the individual have any of the following infectious organisms?</p> <p> <input type="checkbox"/> C-dif<br/> <input type="checkbox"/> MRSA<br/> <input type="checkbox"/> TB </p> | <p> <input type="checkbox"/> VRE<br/> <input type="checkbox"/> Other ☞<br/> <input type="checkbox"/> None </p> | <p>If you selected 'Other,' please specify:</p> |
|--|--|---|

|  |   |
|--|---|
| <p>Are there any allergies?</p> <p> <input type="checkbox"/> Yes ☞<br/> <input type="checkbox"/> No </p> | <p>If you selected 'Yes,' please specify:</p> |
|--|---|

What was the date of onset / surgery? (yyyy-mm-dd)

|  |  |
|--|--|
| <p>Was there a head injury?</p> <p> <input type="checkbox"/> Yes ☞<br/> <input type="checkbox"/> No </p> | <p>If there was a head injury, what was the Glasgow Coma Scale? (Number between 3-15)</p>  |
|  | <p>If there was a head injury, what was the length of the coma?</p>  |
|  | <p>If there was a head injury, is there post-traumatic amnesia?</p> <p> <input type="checkbox"/> Yes<br/> <input type="checkbox"/> No </p> |



# Rehabilitation Integrated Transition Tracking System (RITTS)

---

|   |   |
|---|---|
| Please list medications:  |   |
|   |   |
| Select one of the following designated discharge environments:  | If you selected "Other," please specify:  |
| <input type="checkbox"/> Complex care<br><input type="checkbox"/> Continuing care<br><input type="checkbox"/> Home<br><input type="checkbox"/> Long term care       | <input type="checkbox"/> Not yet explored<br><input type="checkbox"/> Nursing home<br><input type="checkbox"/> Retirement Home<br><input type="checkbox"/> Other <i>☞</i> |
| Is there a psychiatric history?   | If there are patient-identified concerns, please specify:   |
| <input type="checkbox"/> Yes<br><input type="checkbox"/> No   |   |
| Other information and/or investigations and tests to follow via fax or mail.<br>(A facility's contact information can be found using the Find a Rehab Service tab.) |   |
|   |   |

**Please forward all pertinent investigative reports and consult notes.**