



Rehabilitation Integrated Transition Tracking System (RITTS)

Questions from the RITTS - Amputee 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?

Is the secondary diagnosis oncology related? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If you answered "Yes," what is the treatment plan?
	If you answered "Yes," what is the prognosis?
	If you answered "Yes," is the patient aware of their prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No

What is the major reason for the referral? <input type="checkbox"/> Activities of daily living <input type="checkbox"/> Pain Management <input type="checkbox"/> Prosthetic Fitting / Gait Training <input type="checkbox"/> Remaining Limb Status <input type="checkbox"/> Seating Needs <input type="checkbox"/> Wound Status <input type="checkbox"/> Other ☞	If you selected "Other," please specify:
---	--

If the individual has any of the following infectious organisms, please specify: <input type="checkbox"/> C-dif <input type="checkbox"/> MRSA <input type="checkbox"/> TB <input type="checkbox"/> VRE <input type="checkbox"/> Other ☞ <input type="checkbox"/> None	If you selected "Other," please specify:
---	--

Please input the results for the following tests / investigations:	Completed	In Progress	N / A
CAT Scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory / Diagnostic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ☞	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected "Other," please specify:

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

What was the date of onset / surgery? (yyyy-mm-dd)	Is there a sitting tolerance of one hour, twice a day? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---




Rehabilitation Integrated Transition Tracking System (RITTS)

Please list medications:

Are there respiratory needs?

- Yes
- No

Select one of the following designated discharge environments:

- Complex care
- Continuing care
- Home
- Long term care
- Not yet explored
- Nursing home
- Retirement Home
- Other 

If you selected "Other," please specify:

Other information and/or investigations and tests to follow via fax or mail.
(A facility's contact information can be found using the Find a Rehab Service tab.)

Please forward all pertinent investigative reports and consult notes.