



## Questions from the RITTS - Geriatric 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?  <input type="checkbox"/> CHF <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> COPD <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes  <input type="checkbox"/> Hypertlipoidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> OA <input type="checkbox"/> Pain Management <input type="checkbox"/> Previous Fractures <input type="checkbox"/> RA <input type="checkbox"/> Other ☞	If you selected "Other", please specify:
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"/> Bowel/Bladder issues <input type="checkbox"/> Cognitive Screening <input type="checkbox"/> Communication Difficulties <input type="checkbox"/> Contractures <input type="checkbox"/> Discharge Planning <input type="checkbox"/> IADL Assessment & Intervention  <input type="checkbox"/> Medication Review <input type="checkbox"/> Pain Management <input type="checkbox"/> Psycho/social issues <input type="checkbox"/> Self-Care Training <input type="checkbox"/> Transfer & Mobility Training <input type="checkbox"/> Other ☞	If you selected "Other", please specify:
Is there a history of substance abuse?  <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If there is a history of substance abuse, please indicate type:
Are there swallowing issues?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there nutritional issues?  <input type="checkbox"/> Yes <input type="checkbox"/> No




# Rehabilitation Integrated Transition Tracking System (RITTS)

If the individual has any of the following infectious organisms, please specify: <input type="checkbox"/> C-dif <input type="checkbox"/> VRE <input type="checkbox"/> MRSA <input type="checkbox"/> Other ☞ <input type="checkbox"/> TB <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"/>
Electrocardiogram		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doppler and result		<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 cognitive impairment?  <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If you answered "Yes", what is the MMSE score? (0-30)			
Is there a sitting tolerance of one hour, twice a day?  <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please list medications:				
Are there respiratory needs?  <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If you answered "Yes", do they have a tracheotomy?  <input type="checkbox"/> Yes <input type="checkbox"/> No	If you answered "Yes", do they have a CiPAP?  <input type="checkbox"/> Yes <input type="checkbox"/> No	If you answered "Yes", do they have a BiPAP?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If you answered "Yes", is the chest X-Ray stable or improving?  <input type="checkbox"/> Stable <input type="checkbox"/> Improving			
	Are there any other respiratory needs?			



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<p>Select one of the following designated discharge environment:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Complex Care</li><li><input type="checkbox"/> Continuing Care</li><li><input type="checkbox"/> Home</li><li><input type="checkbox"/> Long Term Care</li><li><input type="checkbox"/> Not Yet Explored</li><li><input type="checkbox"/> Nursing Home</li><li><input type="checkbox"/> Retirement Home</li><li><input type="checkbox"/> Other </li></ul>	<p>If you selected "Other", please specify:</p>
<p>Are you sending copies of the discharge summary?</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes</li><li><input type="checkbox"/> No</li></ul>	<p>Are you sending copies of consult notes?</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes</li><li><input type="checkbox"/> No</li></ul>
<p>What is the patient's weight bearing status / restriction:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Full Weight Bearing (FWB)</li><li><input type="checkbox"/> Non Weight Bearing (NWB)</li><li><input type="checkbox"/> Partial Weight Bearing (PWB)</li><li><input type="checkbox"/> Toe Touch Weight Bearing (TTWB)</li></ul>	
<p>Are there any medical contra-indications or activity restrictions?</p>	
<p>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.)</p>	

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