Queensway Carleton Hospital | Bruyère Soins continus / Continuing Care | The Ottawa Hospital / L'Hôpital d'Ottawa

fax: (613)721-4757 (613)562-6095 (613)733-8336

(please circle facility to be faxed to)

☐Short Term ☐Long Term ☐Geri ☐Stroke ☐NMSK ☐ABI ☐Amputee

REHABILITATION DEPARTMENT

REHABILITATION INTERDISCIPLINARY APPLICATION

ADMISSION DATE:

REASON FOR ADMISSION/DIAGNOSIS: SURGERY DATE:

DIAGNOSIS / ACTIVE MEDICAL ISSUES ☐ attached History/Physical/Consult D.N.R. ☐ no ☐ yes

☐ MRSA (+/-) ☐ VRE (+/-) ☐ TB ☐ CDIFF ☐UTI ☐ HIV ☐ Hepatitis Isolation: ☐ no ☐ yes

SOCIAL HISTORY:

Residence Type: ☐ Multi-storey home ☐ Bungalow ☐ Apartment ☐ Retirement Home ☐ LTC

Social Support: ☐ Patient is a caregiver ☐Lives with spouse ☐ Lives with family ☐ Lives alone

Preferred Language: ☐ English ☐ French ☐ Other _____________ Smokes: ☐ no ☐ yes ________

Alcohol consumption: ☐ no ☐ yes _______________ Insurance Coverage: ☐ ward ☐ semi ☐ private

ACTIVITIES AND PARTICIPATION:

ACTIVITY	3 MONTHS AGO	CURRENT	COMMENT	FIM LEVELS NO HELPER
Self-Care				
Eating				**7** Complete Independence (timely, safely)
Grooming				
Bathing				
Dressing – Upper Body				**6** Modified Independence (device)
Dressing – Lower Body				
Toileting				
Sphincter				**HELPER**
Bladder Management				Modified Dependence
Bowel Management				**5** Supervision
Transfers				**4** Minimal Assistance (subject = 75%)
Bed, Chair, Wheelchair				
Toilet				
Tub, Shower				**3** Moderate Assistance (subject = 50%)
Locomotion				
Walk//Wheelchair				
Stairs				
Communication				Complete Dependence
Comprehension				**2** Maximal Assistance (subject = 25% +)
Expression				
Social Cognition				
Social Interaction				**1** Total Assistance (subject = 0% +)
Problem Solving				
Memory				

Weight Bearing Status: ☐ FWB ☐ PWB until: ________ ☐ Feather/Toe Touch WB until: ___________

Weight Bearing orders signed by physician: ☐ attached

Endurance: ☐ Sitting time: _________________ hr, Frequency _______________/day

☐ Therapy time: ________________ hr, Frequency ______________/day (OT,PT,SLP,etc.)

☐ Sitting Balance: ☐ Poor ☐ Minimum Assistance ☐ Independent

Safety Issues: (Falls , Impulsive , Wandering): ☐ no ☐ yes Fall Risk Score: ____________

☐ Last fall risk tool attached

Comments:

Swallowing / Diet: ☐ Normal ☐ Modified Diet: ________________________________ ☐ Tube Feeding:

Mood: ☐ Aggression ☐ Depression ☐ Sleep Issues ☐ No Concerns Geri Depression Scale:_______/15

Cognitive Impairment: ☐ no ☐ yes Cognitive Test and Score:

Details:

Communication impairment: ☐ Aphasic ☐ Motor Speech Disorder Details:

Skin Status: Breakdown ☐ no ☐ yes Stage / Location: ______________ Last Braden Scale: attached ☐

Type of dressing / frequency:

Ability to Initiate own care: ☐ no ☐ yes Details:

SPECIAL NEEDS / EQUIPMENT Check all that apply:

☐ IV meds ☐ PICC ☐ feeding tube (type):

☐ Oxygen ☐ Tracheotomy ☐ Bi-Pap ☐ C-Pap Comment:

☐ Dialysis

☐ Chemotherapy / Radiation treatment

☐ Bariatric equipment (type):

☐ Negative Pressure dressing (location):

☐ Assistive devices:

☐ Braces / splints (type):

INVESTIGATIONS: **MUST SEND**

☐ All relevant investigations: X-ray, CT, MRI, U/S, Echocardiogram , other:

☐ All recent laboratory results

☐ Current list of medications

☐ Relevant allied health notes

Details:

Previous community supports: ☐ no ☐ yes

Discharge Planning post- rehab addressed: ☐ no ☐ yes

Family/Discharge Issues: ☐ no ☐ yes Comment:

Recommended rehab intervention by: NURSE/ PT /OT /SLP /DIETARY /PHARMACIST /SOCIAL WORKER (please circle)

Interdisciplinary goals / comments:

Completed by: ☐ Physiotherapist ☐ Occupational Therapist ☐ Nurse ☐ Social Worker ☐ Speech Therapist

Date: Name:

Phone / pager:

Date application received: ☐ complete ☐ incomplete

Date completed:

Accepted date: Accepted by:

Ready for discharge to rehab unit: ☐ no ☐ yes If no, ready by: (date)

Refusal date: Refused by:

Reason for refusal:

Suggested alternatives:

Facility advised of decision: ☐ no ☐ yes