



Questions from the RITTS - Musculoskeletal 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? <input type="checkbox"/> Arthritic disorders <input type="checkbox"/> Burns <input type="checkbox"/> Deconditioning Syndrome <input type="checkbox"/> Multiple Trauma <input type="checkbox"/> Orthopaedic conditions	<input type="checkbox"/> Pain: Muscular/joint <input type="checkbox"/> Soft tissue disorders <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Other ☞	If you selected "Other", please specify:
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What is the secondary diagnosis? <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Depression <input type="checkbox"/> Hypertension	<input type="checkbox"/> OA <input type="checkbox"/> Pain Management <input type="checkbox"/> RA <input type="checkbox"/> Other ☞	If you selected "Other," please specify:
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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

Are there swallowing issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there nutritional issues? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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:
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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:			



Rehabilitation Integrated Transition Tracking System (RITTS)

<p>Are there any allergies?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you selected 'Yes,' please specify:</p>	
<p>What was the date of injury / surgery? (yyyy-mm-dd)</p>		
<p>What was the cause of the injury / surgery?</p>		
<p>Is there a sitting tolerance of one hour, twice a day?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>		
<p>Please list medications:</p>		
<p>Are there respiratory needs?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If there are respiratory needs, do they have a tracheotomy?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If they have a tracheotomy, how often is suction needed in a 24-hour period?</p>
	<p>If there are respiratory needs, do they have a CiPAP?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>If there are respiratory needs, do they have a BiPAP?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
	<p>Are there any other respiratory needs?</p>	
<p>Are there patient-identified goals?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you answered "Yes," please list:</p>	



Rehabilitation Integrated Transition Tracking System (RITTS)

Select one of the following designated discharge environments:		If you selected "Other," please specify:
<input type="checkbox"/> Complex care	<input type="checkbox"/> Not yet explored	
<input type="checkbox"/> Continuing care	<input type="checkbox"/> Nursing home	
<input type="checkbox"/> Home	<input type="checkbox"/> Retirement Home	
<input type="checkbox"/> Long term care	<input type="checkbox"/> Other ☞	
What is the patient's weight-bearing status/restriction?	If post-trauma or surgery, what is the skin or wound status?	
<input type="checkbox"/> Full Weight Bearing (FWB)		
<input type="checkbox"/> Non Weight Bearing (NWB)		
<input type="checkbox"/> Partial Weight Bearing (PWB)		
<input type="checkbox"/> Toe Touch Weight Bearing (TTWB)		
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.