



Questions from the RITTS – Neurological Disorders 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?

Is the primary diagnosis oncology related? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	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 secondary diagnosis / Other Medical Co-Morbidities?

What is the major reason for the referral? <input type="checkbox"/> Activities of daily living <input type="checkbox"/> Bowel/Bladder issues <input type="checkbox"/> Communication problems <input type="checkbox"/> Contractures <input type="checkbox"/> Deconditioning <input type="checkbox"/> Equipment needs <input type="checkbox"/> Housing needs <input type="checkbox"/> Mobility issues	<input type="checkbox"/> Pain management <input type="checkbox"/> Pressure sores <input type="checkbox"/> Psycho/social issues <input type="checkbox"/> Seating needs <input type="checkbox"/> Spasm management <input type="checkbox"/> Technology Access Services <input type="checkbox"/> Transfers (and Mobility Training) <input type="checkbox"/> Other ☞	If you answered "Other," please specify:
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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"/>
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:			



Rehabilitation Integrated Transition Tracking System (RITTS)

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 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," is the patient on a mechanical ventilator? <input type="checkbox"/> Yes <input type="checkbox"/> No		If they have a tracheotomy, how often is suction needed in a 24-hour period?
	If there are respiratory needs, are there chest complications / infections? <input type="checkbox"/> Yes <input type="checkbox"/> No		If there are respiratory needs, is the chest x-ray stable or improving? <input type="checkbox"/> Stable <input type="checkbox"/> Improving
	If there are respiratory needs, is peak cough flow greater than 200 lpm? <input type="checkbox"/> Yes <input type="checkbox"/> No		If there are respiratory needs, what is the oxygen saturation while on room air? (Equal or greater than 95%) <input type="checkbox"/> Equal to 95% <input type="checkbox"/> Greater than 95% <input type="checkbox"/> Less than 95%
	If there are respiratory needs, is there sleep disordered breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there patient-identified goals? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No		If you answered "Yes," please list:	



Rehabilitation Integrated Transition Tracking System (RITTS)

<p>Select one of the following designated discharge environments:</p> <table><tr><td><input type="checkbox"/> Complex care</td><td><input type="checkbox"/> Not yet explored</td></tr><tr><td><input type="checkbox"/> Continuing care</td><td><input type="checkbox"/> Nursing home</td></tr><tr><td><input type="checkbox"/> Home</td><td><input type="checkbox"/> Retirement Home</td></tr><tr><td><input type="checkbox"/> Long term care</td><td><input type="checkbox"/> Other <i>☞</i></td></tr></table>	<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 <i>☞</i>	<p>If you selected "Other," please specify:</p>
<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 <i>☞</i>								
<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.