

### Rehab Criteria

- The patient must have a physical impairment requiring rehabilitation OR have a known cognitive impairment requiring ongoing rehabilitation support or services.
- The patient is medically stable:
  - A clear diagnosis and co-morbidities have been established*
  - At the time of discharge from acute care, acute medical issues have been addressed: disease processes and/or impairments are not precluding participation in rehab program.*
  - Patient's vital signs are stable.*
  - No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).*
  - Medication needs have been determined.*
- The patient or a substitute decision-maker must willingly consent to participate in a rehabilitation program.
- The patient or a substitute decision-maker has identified realistic, specific, measurable and timely, functional goals for the rehabilitation process.
- The patient referred to an Inpatient Specialized service must be able to tolerate therapy sessions for a minimum of 15-30 minutes twice a day and must have the cognitive ability to participate in and benefit from a rehabilitation program.



# Rehabilitation Integrated Transition Tracking System (RITTS)

Demographics, Referral Information and Medical Information			
Surname:		Given Name:	
Address:		Date of Birth:	
City:	Province:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Health Card #:
Postal Code:	Home Phone:	Marital Status:	
Substitute Decision Maker:		Phone #: _____	Relationship to Patient:
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (Specify): _____		Referring Institution:	
Referring Physician:		Family Physician:	
Contact Person for Clinical Information:		Phone #: _____	Pager #: _____
Contact Person for Bed Offer: <input type="checkbox"/> Same as above		Phone #: _____	Pager #: _____
Insurance Coverage: <input type="checkbox"/> Ward <input type="checkbox"/> Semi <input type="checkbox"/> Private <input type="checkbox"/> Not Applicable			
Infections: <input type="checkbox"/> MRSA + <input type="checkbox"/> VRE + <input type="checkbox"/> CDIFF <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other (Specify): _____			
Isolation Required: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Date of Stroke:		Location of Stroke:	
Type of Stroke: <input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Other (Specify): _____			
History of Presenting Illness:			
Current Active Medical Issues:			
Any pending investigations or follow-up? <input type="checkbox"/> Yes <input type="checkbox"/> No (Details): _____			
Past Medical History:			
Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (Details): _____			
Goals of Rehabilitation:			
Social Information			
Residence Type: <input type="checkbox"/> LTC <input type="checkbox"/> Home <input type="checkbox"/> Retirement Home (Name): _____			
Family Support / Community Supports:			



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Alpha-FIM® module			
If you have Alpha-FIM data present, please provide it in the fields below:			<input type="checkbox"/> I do not have Alpha-FIM data
Impairment Group:			
<b>Discharge to</b>	Planned:	Actual:	
Has the patient been observed walking 150 feet or more? <span style="float: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</span>			
<i>If yes: Raw Ratings</i>	Bed / Chair Transfer:	Expression:	Toilet Transfer:
	Bowel:	Walk:	Memory:
<i>If no: Raw Ratings</i>	Eating:	Expression:	Toilet Transfer:
	Bowel:	Grooming:	Memory:
<b>Projected</b>			
	FIM-13 Raw Motor:	FIM-5 Raw Cognition:	
	FIM-13 Rasch Motor:	FIM-5 Rasch Cognition:	
	FIM Motor Range:	FIM Cognition Range:	
	FIM Walking Range:	Help Needed:	
<b>Continence</b>			
Bladder: <input type="checkbox"/> Continent <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Total Incontinence <input type="checkbox"/> Catheter <input type="checkbox"/> Other: _____			
Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Total Incontinence <input type="checkbox"/> Colostomy (Brand & Size): _____ <input type="checkbox"/> Ileostomy (Brand & Size): _____ <input type="checkbox"/> Other: _____			
<b>Skin Status</b>			
Skin Breakdown: <input type="checkbox"/> No <input type="checkbox"/> Yes			
All Stages/Locations: <i>(only answer if you said 'Yes' to Skin Breakdown)</i>			
Type of dressing used / Frequency of dressing changes: <i>(only answer if you said 'Yes' to Skin Breakdown)</i>			
<b>Swallowing / Nutrition</b>			
Swallowing Disorder: <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Not Applicable		If new, has videofluoroscopy / FEES been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Diet Order:	<input type="checkbox"/> DAT <input type="checkbox"/> Diabetic	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Other (Details): _____
Method of Intake:	<input type="checkbox"/> ORAL <input type="checkbox"/> PEG <input type="checkbox"/> NG	<input type="checkbox"/> NPO	<input type="checkbox"/> Other (Details): _____
Adjusted Diet – Solids:	<input type="checkbox"/> DAT <input type="checkbox"/> Minced diet <input type="checkbox"/> Pureed diet	<input type="checkbox"/> Dental soft diet	<input type="checkbox"/> Other (Details): _____
Adjusted Diet – Liquids:	<input type="checkbox"/> Thin <input type="checkbox"/> Nectar thick <input type="checkbox"/> Honey thick	<input type="checkbox"/> Sips of water only	<input type="checkbox"/> Other (Details): _____
<b>Communication</b>			
Speech: <input type="checkbox"/> Receptive Aphasia (difficulty understanding language) <input type="checkbox"/> Dysarthria (slurred speech)		<input type="checkbox"/> Expressive Aphasia (difficulty producing language) <input type="checkbox"/> Not Applicable	
Can patient communicate needs? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With Difficulty</span>			
Can patient consistently follow one step verbal or gestural commands? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Additional Details:			

<b>Cognition and Perception</b>		
Is there a cognitive impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unable to Assess Details: _____		
MMSE Score: _____ /30	MOCA Score: _____ /30	Other (Specify): _____ + score _____
Has the patient shown the ability to learn and retain information? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Does the patient have an adequate attention span to allow participation in activities for 30 minutes at a time? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
<b>Mood / Behaviour</b>		
<input type="checkbox"/> Cooperative <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Anxiety <input type="checkbox"/> Agitation <input type="checkbox"/> Wandering <input type="checkbox"/> Need for restraints <input type="checkbox"/> Need for sitter <input type="checkbox"/> Sleep issues <input type="checkbox"/> Depression <input type="checkbox"/> Psychiatric Issues		
Details:		
<b>Special Needs/Equipment</b>		
<input type="checkbox"/> IV therapy <input type="checkbox"/> PICC <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Oxygen <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Dialysis <input type="checkbox"/> C-Pap <input type="checkbox"/> Bi-Pap <input type="checkbox"/> Braces/Splints <input type="checkbox"/> CADD <input type="checkbox"/> Suction <input type="checkbox"/> VAC <input type="checkbox"/> Special Mattress <input type="checkbox"/> Specialized Equipment <input type="checkbox"/> Chemotherapy or Radiation Treatment <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other		
If Dialysis: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal	If Specialized Equipment: <input type="checkbox"/> Height over 6ft/183 cm (Details:) _____ <input type="checkbox"/> Weight over 250 lbs / 113 kg (Details:) _____	
Provide details for <u>all</u> items checked: <i>[on the RITTS, a text box will appear under each checked box]</i>		
<b>Abilities/ Tolerance and Functional Status</b>		
Sitting Tolerance: <input type="checkbox"/> Has not been up <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> 1-2 hours <input type="checkbox"/> > 2 hours		
Physical Activity Tolerance: <input type="checkbox"/> less than 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> > 1 hour		
Mental Activity Tolerance: <input type="checkbox"/> less than 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> > 1 hour		
Bed Mobility (Self positioning in bed): <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Mechanical Lift		
Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Mechanical Lift		
Ambulation: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist x1 <input type="checkbox"/> Assist x2 <input type="checkbox"/> Has not ambulated		
Mobility Aid: <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker Type: _____ <input type="checkbox"/> Wheelchair Type: _____ <input type="checkbox"/> Not Applicable		



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Activities of Daily Living (ADLs)						
Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Eating: <i>(Ability to feed self)</i>						
Grooming: <i>(Ability to wash face/hands, comb hair, brush teeth)</i>						
Dressing: <i>(Upper body)</i>						
Dressing: <i>(Lower body)</i>						
Toileting: <i>(Ability to self-toilet)</i>						
Bathing: <i>(Ability to wash self)</i>						
Details:						
Was patient walking independently, with or without a gait aide pre-stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No (Details): _____ <input type="checkbox"/> Unknown						
Were ADLs independent pre-stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No (How much assistance required?) _____						
Motivation to participate in Rehabilitation: <input type="checkbox"/> Demonstrates motivation to participate including: regular attendance/involvement and cooperation <input type="checkbox"/> Usually motivated to participate, occasional frustration apparent <input type="checkbox"/> Motivated to participate but attendance, involvement or cooperation irregular						

- Please Send:**
- All relevant cognitive perceptual testing (MMSE, MOCA, etc.)
  - All relevant investigations (X-RAY, CT, MRI, US, ECHO, etc.)
  - All recent laboratory investigations
  - Current list of medication
  - All relevant health professional notes (PT, OT, SLP, etc.)
  - If applying for Low Intensity Long Duration – “Complex Continuing Care Facility Choice List”

<b>Completed by:</b>	<b>Title:</b>	<b>Date:</b>
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