



Rehabilitation Integrated Transition Tracking System (RITTS)

Questions from the RITTS – Stroke 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 / Other Medical Co-Morbidities?

Is the secondary diagnosis oncology related? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If you answered "Yes," is the prognosis more than 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
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What is the major reason for the referral? <input type="checkbox"/> ADL <input type="checkbox"/> Ambulation <input type="checkbox"/> Equipment needs <input type="checkbox"/> Memory <input type="checkbox"/> Orthotics	<input type="checkbox"/> Speech <input type="checkbox"/> Stroke prevention (excludes and redirects the referral) <input type="checkbox"/> Swallowing <input type="checkbox"/> Other ☞	If you selected "Other," please specify:
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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"/>
Echocardiogram	<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:
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What was the date of onset? (yyyy-mm-dd)	
Is a head injury the primary cause of disability? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	
Is there a sitting tolerance of 1 hour twice a day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have seizures? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If you selected "Yes," is the individual on medication? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No
Please list medications:	
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.