Access to Care | Right Care | Right Time | Right Place

Complex Continuing Care and Rehabilitation

SW LHIN Rehabilitation Eligibility Guidelines

Name: _____ HIN: _____

Referring site: _____ Date: _____

Definition: According to the World Health organization, Rehabilitation is a progressive, dynamic goal-oriented and often time- limited process, which enables an individual with impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level.

1. The patient has sufficient cognitive skills to set and attain functional goals, demonstrate regular progress, and readily integrate new learning skills into daily life.
2. The patient requires access to inter-professional staff, where periodic changes to the care plan and ongoing re-definition of therapeutic goals are required.
3. The patient requires a progressive, goal-oriented plan of care to reach an optimal level of mental, physical, cognitive and/or social well -being.
4. The patient and/or substitute decision maker has consented to treatment in the program and demonstrates a willingness and motivation to participate in the rehabilitation program.
5. The patient is not able to be managed in the community by CCAC services, informal care givers and/or other community services, and is not a candidate for LTC at this time.
6. Active treatment that results in the patient's frequent absences from the unit during the rehabilitation treatment session must not interfere with the patient's ability to participate in the rehabilitation.

Eligibility Criteria Checklist

- Is 18 years or older (pediatric population by exception only) ☐Yes ☐ No
- Has a clear diagnosis and co- morbidities identified ☐Yes ☐ No
- Is medically and surgically stable, ie. all reasons for acute care stay have been stabilized and/or reached a plateau ☐Yes ☐No
- Has completed all consults and diagnostic tests for the purposes of diagnosis or treatment of acute conditions ☐Yes ☐ No
- Has acknowledged and addressed all abnormal laboratory values, as required ☐Yes ☐ No
- Has no substance abuse and/or mental health issues, which would limit the patient's ability to participate in the program, and does not demonstrate behaviours that could be harmful to themselves and/or others ☐Yes ☐No
- Has been screened for all infection control concerns ☐Yes ☐No
- Has established functional goals, which are specific, measurable, realistic and timely ☐Yes ☐ No
- Is able to sit for 1 hour, 2- 3 times per day, and tolerate 2 therapies per day ☐Yes ☐ No
- Is committed to returning to the community, utilizing family and/or community support services, as required ☐Yes ☐ No
- Has a documented discharge destination ☐Yes ☐ No
- Has a follow-up plan in place at the time of referral, and follow-up appointments scheduled by the acute site at the time of discharge ☐Yes ☐ No
- Has determined special equipment needs ☐Yes ☐ No

Eligible: ☐ Yes ☐ No **Priority Code** (definitions on page 2):

Comments: _____

Signature of Assessor: _____ Date: _____

Priority Code Definitions

Priority 1 "Crisis"- the Patient's needs can be met in Rehabilitation and requires immediate admission (within days, not weeks) in order to optimize Rehab outcomes. This includes Acute Stroke patients.

Priority 2 "Readmission/Change in Stream"- A current Rehabilitation patient who needs another Rehabilitation stream, or a previous Rehabilitation patient transferred out due to an acute episode and is now medically stable and needs to return to a Rehabilitation bed.

Priority 3 "All Others"- Patient eligible for Rehabilitation and does not meet the requirements for Priority 1 or 2.

FACILITY CHOICES	RANK

Acute Care to Rehab & Complex Continuing Care (CCC) Referral

Insert Health Service Provider Logo

Identify Referral Destination: ☐ *Referral to Rehab*
☐ *Referral to Complex Continuing Care (CCC)*

Patient Identification

If Faxed Include Number of Pages (Including Cover): _____ Pages

Estimated Date of Rehab/CCC Readiness: DD/MM/YYYY

Patient Details and Demographics

Health Card #: Version Code: Province Issuing Health Card:
No Health Card #: ☐ No Version Code: ☐

Surname: Given Name(s):

No Known Address: ☐

Home Address: City: Province:

Postal Code: Country: Telephone: Alternate Telephone:
No Alternate Telephone: ☐

Current Place of Residence (Complete If Different From Home Address) :

Date of Birth: DD/MM/YYYY Gender: ☐ M ☐ F ☐ Other_____ Marital Status:

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French ☐ Other _____

Primary Alternate Contact Person:

Relationship to Patient(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other_____

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Secondary Alternate Contact Person: None Provided: ☐

Relationship to Patient(Please check all applicable boxes) : ☐ POA ☐ SDM ☐ Spouse ☐ Other _____

Telephone: Alternate Telephone: No Alternate Telephone: ☐

Insurance: N/A: ☐ Program Requested:

Current Location Name: Current Location Address: City:

Province: Postal Code:

Current Location Contact Number: Bed Offer Contact (Name): Bed Offer Contact Number:

Acute Care to Rehab & Complex Continuing Care (CCC) Referral

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Patient Identification

Medical Information

Primary Health Care Provider (e.g. MD or NP) Surname: Given Name(s):

☐ None

Reason for Referral:

Allergies: ☐ No Known Allergies ☐ Yes --- If Yes, List Allergies:

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (Specify):_____

Admission Date: DD/MM/YYYY Date of Injury/Event: DD/MM/YYYY Surgery Date: DD/MM/YYYY

Rehab Specific Patient Goals:

CCC Specific Patient Goals:

Nature/Type of Injury/Event:

Primary Diagnosis:

History of Presenting Illness/Course in Hospital:

Current Active Medical Issues/Medical Services Following Patient:

Past Medical History:

Height: Weight:

Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____

Location: _____

Is Patient Currently Receiving Chemotherapy: ☐ Yes ☐ No Frequency: _____ Duration:_____

Location: _____

Acute Care to Rehab & Complex Continuing Care (CCC) Referral

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Patient Identification

Is Patient Currently Receiving Radiation Therapy: ☐ Yes ☐ No Frequency: _____ Duration:_____

Location:_____

Concurrent Treatment Requirements Off-Site: ☐ Yes ☐ No Details:

CCC Specific

Medical Prognosis: ☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Palliative ☐ Unknown Palliative Performance Scale:_____

Services Consulted: ☐ PT ☐ OT ☐ SW ☐ Speech and Language Pathology ☐ Nutrition ☐ Other_____

Pending Investigations: ☐ Yes ☐ No Details:

Frequency of Lab Tests: _____ ☐ Unknown ☐ None

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements?: ☐ Yes ☐ No -- If No, Skip to Next Section

Supplemental Oxygen: ☐ Yes ☐ No Ventilator: ☐ Yes ☐ No

Breath Stacking: ☐ Yes ☐ No Insufflation/Exsufflation: ☐ Yes ☐ No

Tracheostomy: ☐ Yes ☐ No ☐ Cuffed ☐ Cuffless

Suctioning: ☐ Yes ☐ No Frequency:

C-PAP: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

Bi-PAP: ☐ Yes ☐ No Rescue Rate: ☐ Yes ☐ No Patient Owned: ☐ Yes ☐ No

Additional Comments:

IV Therapy

IV in Use?: ☐ Yes ☐ No -- If No, Skip to Next Section

IV Therapy: ☐ Yes ☐ No Central Line: ☐ Yes ☐ No PICC Line : ☐ Yes ☐ No

Swallowing and Nutrition

Swallowing Deficit: ☐ Yes ☐ No Swallowing Assessment Completed: ☐ Yes ☐ No

Type of Swallowing Deficit Including any Additional Details:

TPN: ☐ Yes (If Yes, Include Prescription With Referral) ☐ No

Enteral Feeding: ☐ Yes ☐ No

Acute Care to Rehab & Complex Continuing Care (CCC) Referral

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Patient Identification

Skin Condition

Surgical Wounds and/or Other Wounds Ulcers: ☐ Yes ☐ No -- If No, Skip to Next Section

1. Location: Stage:

Dressing Type: Frequency:
(e.g. Negative Pressure Wound Therapy or VAC)

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

2. Location: Stage:

Dressing Type:
(e.g. Negative Pressure Wound Therapy or VAC) Frequency:

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

3. Location: Stage:

Dressing Type:
(e.g. Negative Pressure Wound Therapy or VAC) Frequency:

Time to Complete Dressing: ☐ Less Than 30 Minutes ☐ Greater Than 30 Minutes

If additional wounds exist, add supplementary information on a separate sheet of paper.

Continence

Is Patient Continent?: ☐ Yes ☐ No -- If Yes, Skip to Next Section

Bladder Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Bowel Continent: ☐ Yes ☐ No If No: ☐ Occasional Incontinence ☐ Incontinent

Pain Care Requirements

Does the Patient Have a Pain Management Strategy?: ☐ Yes ☐ No -- If No, Skip to Next Section

Controlled With Oral Analgesics: ☐ Yes ☐ No

Medication Pump: ☐ Yes ☐ No

Epidural: ☐ Yes ☐ No

Has a Pain Plan of Care Been Started: ☐ Yes ☐ No

Communication

Does the Patient Have a Communication Impairment?: ☐ Yes ☐ No -- If No, Skip to Next Section

Communication Impairment Description:

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Patient Identification

Cognition

Cognitive Impairment: ☐ Yes ☐ No ☐ Unable to Assess -- If No, or Unable to Assess, Skip to Next Section

Details on Cognitive Deficits:

Has the Patient Shown the Ability to Learn and Retain Information: ☐ Yes ☐ No -- If No, Details:

Delirium: ☐ Yes ☐ No -- If Yes, Cause/Details:

History of Diagnosed Dementia: ☐ Yes ☐ No

Behaviour

Are There Behavioural Issues: ☐ Yes ☐ No -- If No, Skip to Next Section

Does the Patient Have a Behaviour Management Strategy?: ☐ Yes ☐ No

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation ☐ Wandering

☐ Sun downing ☐ Exit-Seeking ☐ Resisting Care ☐ Other

☐ Restraints -- If Yes, Type/Frequency Details :

Level of Security: ☐ Non-Secure Unit ☐ Secure Unit ☐ Wander Guard ☐ One-to-one

Social History

Discharge Destination: ☐ Multi-Storey ☐ Bungalow ☐ Apartment ☐ LTC

☐ Retirement Home (Name):

Accommodation Barriers: ☐ Unknown

Smoking: ☐ Yes ☐ No Details:

Alcohol and/or Drug Use: ☐ Yes ☐ No Details:

Previous Community Supports: ☐ Yes ☐ No Details:

Discharge Planning Post Hospitalization Addressed: ☐ Yes ☐ No Details:

Discharge Plan Discussed With Patient/SDM: ☐ Yes ☐ No

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Patient Identification

Current Functional Status

Sitting Tolerance: ☐ More Than 2 Hours Daily ☐ 1-2 Hours Daily ☐ Less Than 1 Hour Daily ☐ Has not Been Up

Transfers: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Mechanical Lift

Ambulation: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2 ☐ Unable

Number of Metres: _____

Weight Bearing Status: ☐ Full ☐ As Tolerated ☐ Partial ☐ Toe Touch ☐ Non

Bed Mobility: ☐ Independent ☐ Supervision ☐ Assist x1 ☐ Assist x2

Activities of Daily Living

Level of Function Prior to Hospital Admission (ADL & IADL) :

Current Status – Complete the Table Below:

Activity	Independent	Cueing/Set-up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Eating: (Ability to feed self)						
Grooming: (Ability to wash face/hands, comb hair, brush teeth)						
Dressing: (Upper body)						
Dressing: (Lower body)						
Toileting: (Ability to self-toilet)						
Bathing: (Ability to wash self)						

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Patient Identification

Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No -- If No, Skip to Next Section

☐ HALO ☐ Orthosis ☐ Bariatric ☐ Other_____

Pleuracentesis: ☐ Yes ☐ No	Need for a Specialized Mattress: ☐ Yes ☐ No
Paracentesis: ☐ Yes ☐ No	Negative Pressure Wound Therapy (NPWT): ☐ Yes ☐ No

Rehab Specific
AlphaFIM® Instrument

Is AlphaFIM® Data Available: ☐ Yes ☐ No -- If No, Skip to Next Section

Has the Patient Been Observed Walking 150 Feet or More: ☐ Yes ☐ No

If Yes – Raw Ratings (levels 1-7):	Transfers: Bed, Chair_____	Expression_____	Transfers: Toilet_____
	Bowel Management _____	Locomotion: Walk_____	Memory_____
If No – Raw Ratings (levels 1-7):	Eating_____	Expression_____	Transfers: Toilet_____
	Bowel Management_____	Grooming_____	Memory_____
Projected:	FIM® projected Raw Motor (13):	FIM® projected Cognitive (5):	
	Help Needed:		

Attachments

Details on Other Relevant Information That Would Assist With This Referral:

Please Include With This Referral:

☐ Admission History and Physical

☐ Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician)

☐ All relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US etc.)

☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present)

Completed By: **Title:** **Date:** DD/MM/YYYY

Contact Number: **Direct Unit Phone Number:**