Hotel Dieu Shaver Health and Rehabilitation Centre

Complex Care & Rehabilitation Application Form

**** Required Field***

Patient Name* _____ **HCN*** _____ **VC*** _____ **DOB*** _____ **Gender*** _____
Address* _____ **City*** _____ **Province*** _____ **Postal Code*** _____
Patient Phone* _____ **Height*** _____ **Weight*** _____ **Hospital Admission Date*** _____
Primary Language* ❑ English ❑ French ❑ Other – specify _____ **Patient Speaks and Understands English*** ❑ Yes ❑ No
Interpreter Needed* ❑ Yes ❑ No Specify _____ **Family Physician*** _____

Emergency Contact Number

Primary Contact* _____ **Relationship*** _____ **Phone*** _____
Power of Attorney Personal Care _____ **Phone** _____
Power of Attorney Financial Care _____ **Phone** _____
Substitute Decision Maker _____ **Phone** _____
Public Guardian & Trustee _____ **Phone** _____

Referral Source

Hospital Site* _____ **Sending Unit*** _____ **Community Agency** _____
Primary Contact for Bed Offer* _____
Phone* _____ **Fax*** _____ **Cell Phone*** _____

Application Stream and Choices

High intensity Rehab Bed Type* _____ **Readiness Date*** _____
For Stroke / Neuro Rehab only - ❑ Alpha FIM Score _____
OR
Complex Care / Rehab Stream* ❑ Rehab Low Intensity – Restorative ❑ Short-Term Complex Medical Management ❑ EOL

Isolation Status

Isolation* ❑ Yes ❑ No **ARO Status** ❑ MRSA ❑ VRE ❑ C-diff ❑ Other – specify _____

Discharge Plan (Destination and Care Plan)

❑ **Home** ❑ **Supervised or Assisted living** ❑ **Retirement Home –** specify _____
❑ **Other –** specify _____-_____
Previous Community Supports? If yes, specify _____
Discharge Plan discussed with patient/family ❑ Yes ❑ No **Date** _____
Information provided to _____ **Information provided by** _____

Planned Discharge – Barriers & Challenges

Describe any known barriers or challenges to discharge (e.g. homelessness, family dynamics, home renovations, no support system)

Patient Name _____ **HCN** _____

Diagnosis / Medical History

Relevant Medical Diagnosis (reason for application) Primary Diagnosis* _____

Relevant Co-Morbidities

Upcoming Appointments / Pending Investigations / Scheduled Tests and/or Procedures ❑ **More information in Clinical Connect**

Type	Physician/Surgeon	Scheduled Date	Notes

❑ **Smoking** ❑ **Alcohol** ❑ **Non-Script Drugs** – specify_____

Allergies* (Medication, Environmental, Food)_____ ❑ **Document(s) attached**

Advanced Directives ❑ Yes ❑ No If yes, please specify_____ ❑ **Document(s) attached**

Palliative Performance Scale (PPS) _____ **Spiritual Needs** _____

Mobility

Weight Bearing Status

Upper Extremity Left	**Date of Assessment**
Upper Extremity Right	**Date of Assessment**
Lower Extremity Left	**Date of Assessment**
Lower Extremity Right	**Date of Assessment**

Current Sitting Tolerance minimum 2-3 hrs/day ❑ Yes ❑ No ❑ More than 2 hrs ❑ 1-2 hrs ❑ Less than 1 hr daily ❑ Has Not Been Up

If no, explain _____

Potential Therapy Tolerance (More than 1 hour per day up to 7 days/week) ❑ Yes ❑ No

If no, explain _____

Bed Mobility (Movement Restrictions/Precautions) _____

Participation Notes

❑ Special Equipment – specify _____

❑ Specialty Bed/Mattress (e.g. Bariatric, air mattress) – specify _____

❑ One Person Transfer

❑ Two Person Transfer

❑ Mechanical Life

Patient Name _____ **HCN** _____

Functional Status and Goals

1=Total Assistance 2=Maximal Assistance 3=Moderate Assistance 4=Minimal Assistance 5=Supervision 6=Modified Independence 7=Complete Independence

	Premorbid Status	Current Status	Required Status to Achieve Discharge Plan (SMART GOALS / Compensatory Strategies)	Demonstrates Recent Progress Y/N	Explain
Self Care					
Eating					
Grooming					
Bathing					
Dressing – Upper Body					
Dressing – Lower Body					
Toileting					
Sphincter Control					
Bladder Management					
Bowel Management					
Mobility/Transfer					
Bed – Chair – Wheelchair					
Toilet					
Tub – Shower					
Locomotion					
Walk – Wheelchair					
Stairs					
Communication					
Comprehension					
Expression					
Social Cognition					
Social Interaction					
Problem Solving					
Memory					

Cognition

Observed Behaviours (Present or exhibited within the last 3 days)

❑ Verbally Responsive ❑ Physically Responsive ❑ Demonstrating Agitation ❑ Resisting Care ❑ Wandering ❑ Sun Downing
❑ Exit Seeking ❑ Bed Exiting ❑ Other_____

Restraints Required? ❑ Yes ❑ No **Restraint Type** ❑ Physical ❑ Chemical ❑ Environmental Specify_____

Behavioural Management Plan attached ❑ Yes ❑ No

Cognitive Assessment Score _____ **Assessment Tool Used**_____

Depression Score_____ **Assessment Tool Used**_____

Patient Name _____ **HCN** _____

Medical Management

❑ Pain Management ❑ Yes ❑ No Pain Pump Type _____

Pain Frequency _____ Pain Intensity _____

❑ Tracheostomy Size _____ Type _____ ❑ Suction – Type _____ ❑ IV Therapy – Access Line _____

❑ Number of wounds and location _____ ❑ Wound Reports attached

❑ Drain(s) Details _____ Negative Pressure Wound Therapy – Details_____

Ostomy / Colostomy ❑ Old ❑ New ❑ Revised ❑ N/A ❑ Ostomy Report attached Level of Care _____ Catheter ❑ Yes ❑ No

❑ Feed Tube _____ Diet Type _____ Fluid Type _____

❑ Halo ❑ Orthosis ❑ Pleuracentesis ❑ Paracentesis

❑ Bi PAP ❑ CPAP (Patient must bring own machine) ❑ Oxygen required ❑ RT required

❑ Chemotherapy Frequency _____ ❑ Radiation Frequency _____

❑ Dialysis Schedule _____ ❑ Peritoneal Dialysis Schedule _____

Other

Relevant Attachments (please provide the following if not available to the receiving organizations electronically)

❑ Recent patient history and relevant assessments/consult notes ❑ Progress notes summarizing current medical conditions (within last 72 hours)

❑ Last relevant lab results ❑ Medication list (BPMH, MAR, medication record, discharge medication record)

Completed by:* Signature* Date*

Patient or Substitute Decision Maker Consent*

I understand the above information and agree to proceed with information sharing for the purpose of a complex care and/or rehabilitation application.

Printed Name of Patient or Substitute Decision Maker* Signature* Date* (dd/mm/yyyy)

Fax Application to:
Hotel Dieu Shaver Health & Rehabilitation Centre
905-685-0206