

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 Information

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

Complex Care/Rehab Stream* _____ CC/LIR Bed Type* _____
 High Intensity Rehab Bed Type* _____ Readiness Date* _____

BCHS HDS HHS HHS-SPH HHS-WLMH HWMH JBH NGH NH-DMH NH-GNG NH-PCH NH-WHS SJHH

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.)

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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 ClinicalConnect

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, 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 Hours 1-2 Hours Less than 1 Hour 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) _____

Neuro Rehab only - Alpha FIM Motor _____ Cognitive _____ Total _____

Participation Notes

Special Equipment - specify _____

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

- One Person Transfer
- Two Person Transfer
- Mechanical Lift

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Functional Status & 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** _____

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Medical Management

- Pain Management Strategy Yes No Pain Pump Type _____
 - Pain Frequency _____ Pain Intensity _____
 - Tracheostomy Size _____ Type _____ Suction – Type _____ IV Therapy - Access Line _____
 - Number of wounds & 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 purposes of a complex care and/or rehabilitation application.

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

<p>Applications for Complex Care and Low Intensity Rehabilitation</p> <p>CCintake@niagarahealth.on.ca HDSintake@hoteldieushaver.org</p>	<p>Applications for High Intensity Rehabilitation Fax to Hospital Programs</p>
	Joseph Brant Hospital: 905-681-4849
	St. Joseph's Healthcare Hamilton: 905-540-6503
	Hamilton Health Sciences: 905-521-2359
	Hotel Dieu Shaver: 905-685-0206
Brant Community Healthcare System: 519-751-5542	