VCH/PHC Inpatient Rehab Application Form

Providence HEALTH CARE

Vancouver CoastalHealth — Promoting wellness. Ensuring care.

Addressograph

GF Strong Rehab Centre
Email: GFSAdmissions@vch.ca
FAX: 604-730-7904

Holy Family Hospital
FAX: 604-321-6886

Lions Gate Hospital
FAX: 604-904-3515

UBC Hospital
FAX: 604-822-7499

Referring Physician: **Contact number:**	**Today's Date:**
Primary Diagnosis:	**Date of Onset:**

REFERRAL SITE & FUNDING INFO

Referring Hospital:_____ Unit:_____ Contact number: _____

Unit Contact Name:_____ □ CML □ CNL □ Other: _____

Funding: □ MSP □ Non-BC □ Worksafe Claim #: □ ICBC Claim #: □ Other:

CLINICAL INFORMATION

Infection Control:
□ None □ MRSA □ VRE
□ CPO □ C-difficile
□ Other_____
Allergies: □ NKA □ Yes

Alpha FIM (Stroke only): _____

Date completed: _____

Medical stability:
□ Normal vital signs > 48 hrs
□ Pain controlled
□ Labs stable
Pending invest. /procedures:

Code status: _____

Please attach the following documentation if available (for last 5 days where applicable):
□ Rehab Consult □ Discharge Summary
□ Progress notes (physician, nursing, allied)
□ Discipline specific assessments (OT, PT, SLP, SW, Nutrition, RRT)
□ MAR □ Labs
□ Wound care plan (if applicable)
□ Care facility consent form

Safety behaviors: □ No concerns
□ Physical/verbal aggression
□ Impulsive
□ Active substance use (drug, alcohol)
□ Wandering risk
□ Other:_____
Requires 1:1 supervision: □ Yes □ No

Communication:
Primary Language:_____
Interpreter required:
□ Yes □ No
□ Aphasia

Nutrition Needs:
□ DAT □ Diabetic Diet □ NPO
□ Dysphagic Diet: □Thickened □ Minced
□ Other: _____
□ PEG (regime) □ NG (exceptions only)
Patient height: _____
Patient weight: _____

Bladder management:
□ Continent □ Incontinence
□ Foley Catheter
□ Intermittent Catheter

Bowel management:
□ Continent
□ Occasional incontinence
□ Incontinence

If incontinent, what are the contributing factors and what is the current management plan?

Skin health:
□ Complex wounds (Braden scale:___)
Location / stage of wound(s):_____
□ Specialty Mattress required
Type:_____

Respiratory needs:
□ O2 : Flow rate: _____
□ CPAP / BiPAP
□ Tracheostomy
type: _____
□ Ventilated

Special medical needs:
□ Bariatric needs (>250lbs)
□ Dialysis (details, days, times):
□ IV therapy (note PICC and Hickman lines accepted at GFS, LGH and CAMU)

PRE-ADMISSION FUNCTIONAL STATUS

ADLs: □ Independent **IADLs**: □ Independent
If impaired, please describe:

Living situation: □ Alone □ With others □ Facility □ Other:_____
Is the home accessible? □ Yes □ No
Supports available: □ None □ Family □ Caregivers □ Community
□ Others:

Employment:
□ Not employed □ Self-employed
□ Employed as:_____

Planned discharge destination:
□ Home alone □ Home with family □ LTC □ Supportive Housing
□ No plan

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CURRENT FUNCTIONAL STATUS

Activity Restrictions: ☐ None
☐ Non WB in: _____
☐ Partial WB in: _____
☐ Precautions:

Cognition:
Able to follow visual/verbal commands ☐ Yes ☐ No
Able to communicate their needs ☐ Yes ☐ No
Able to learn with carry-over ☐ Yes ☐ No
MOCA / MMSE score: _____ Date completed: _____
Details/notable limitations: _____

Activity tolerance:
Sitting tolerance > 2 hrs
☐ Yes ☐ No

Tolerates therapy 2-3 hrs/day
☐ Yes ☐ No

Falls Risk:
☐ Yes ☐ No

Mobility:
Transfers: With OT/PT: ☐ Indep ☐ Super vision ☐ SBA ☐ 1PA ☐ 2PA ☐ Lift
With nursing: ☐ Indep ☐ Super vision ☐ SBA ☐ 1PA ☐ 2PA ☐ Lift
Bed Mobility: ☐ Indep ☐ Super vision ☐ SBA ☐ 1PA ☐ 2PA
Sitting Balance: ☐ Indep ☐ Super vision ☐ SBA ☐ 1PA ☐ 2PA
Ambulation: ☐ None ☐ Indep ☐ Super vision ☐ SBA ☐ 1PA ☐ 2PA
Mobility/Gait Aid:
Wheelchair: ☐ Manual ☐ Power
W/C Measurements: Width: _____ Depth: _____
Body Measurements
Trochanter to trochanter: _____
PSIS to popliteal fossa: _____
Lower leg length: _____

Activities of daily living:

Grooming:	☐ Indep	☐ Supervision	☐ SBA	☐ 1PA	☐ 2 PA	☐ Dependent
Feeding:	☐ Indep	☐ Supervision	☐ SBA	☐ 1PA	☐ 2 PA	☐ Dependent
Dressing:	☐ Indep	☐ Supervision	☐ SBA	☐ 1PA	☐ 2 PA	☐ Dependent
Toileting:	☐ Indep	☐ Supervision	☐ SBA	☐ 1PA	☐ 2 PA	☐ Dependent
Showering:	☐ Indep	☐ Supervision	☐ SBA	☐ 1PA	☐ 2 PA	☐ Dependent

Upcoming appointments: ☐ None

1 _____ Date: _____
2 _____ Date: _____
3 _____ Date: _____
4 _____ Date: _____

Patient agrees to attend Inpatient Rehabilitation: ☐ Yes ☐ No

List functional/realistic rehabilitation goals:

1 _____
2 _____
3 _____
4 _____

FOR USE BY REHAB ADMISSION COORDINATOR ONLY

Referral sent to:
☐ HFH ☐ GFS ☐ LGH ☐ UBCH
Target unit/ program: _____

Planned date of admission:
_____
☐ MD handover call arranged

Meets admission guidelines & ready for admission:
☐ Yes, pending bed availability for patient
☐ No, pending patient status (follow up required):
Notes:

☐ No, patient declined

Form reviewed by:
_____

Date of review:
_____

Created March 2022