The Community Rehab Assessment presented here is not for use or distribution. Select items have had response options deleted to accommodate posting publicly on the Rehabilitation Care Alliance website. It is a truncated version of the tool employed by the Rehab Care Alliance during the Provincial Proof of Concept of the RCA Outpatient/Ambulatory Minimum Data set (2015 – 2017).

The Community Rehab Assessment tool, was developed in collaboration with Dr. Hirdes (U Waterloo) and Dr. Berg (U of Toronto), drawing on the expertise and research of interRAI. interRAI retains copyright for the items.

The assessment has several embedded scales summarizing physical function, activity levels, mobility, mood, pain and single items reporting fatigue, dyspnea and sleep and is completed in two parts:

1. Patient Self-Report Tool
2. In-Clinic Assessment

This assessment is intended to provide the therapist with information valuable to their assessment and treatment plan and to provide outcome information from the rehab program. Results of the pilot demonstrated improvements in function and symptom levels post rehabilitation program.

Further work will be undertaken to refine and revise the assessment based on results of the proof of concept.

Community Rehab Assessment
Patient Self Report Tool

1. **What is your main concern or reason for therapy?**

2. **What are your goals for therapy? What improvements would you like to see? Circle your most important goal(s).**

3. **In general, how would you rate your health?**
   - ◯ Excellent
   - ◯ Good
   - ◯ Fair
   - ◯ Poor

B. Employment

1. **What is your current employment status?**
   - ◯ Employed
   - ◯ Employed, on leave
   - ◯ Unemployed, looking for work
   - ◯ Unemployed, not seeking employment

2. **Are you being accommodated at work? For example, different job or fewer hours due to your current condition or injury?**
   - ◯ No accommodation/do not work
   - ◯ Yes

C. Physical Activity

1. **On average, how much time do you currently spend a week doing the following activities?**

	None	1 to 7 hours	8 to 34 hours	35 or more hours
a. Paid work, either full time or part time				
b. Community/volunteer activities				
c. Social Activities				

2. **Over the last three days, how many hours of exercise / physical activity have you had in total?**

D. Pain

1. **In the last three days, how often have you had pain?**

- ◯ Never
- ◯ Not in the last three days, but do have
- ◯ pain Less than daily
- ◯ Everyday
- ◯ All or most of the time

2. **In the last three days, where have you had pain? (Response Options deleted)**

3. In the last three days, what is the highest level of pain that you experienced?

	No pain	Mild pain	Moderate pain	Severe pain	Horrible or excruciating pain
a. At rest	◯	◯	◯	◯	◯
b. Routine daily tasks	◯	◯	◯	◯	◯
c. Moderate or vigorous activity	◯	◯	◯	◯	◯

4. How adequate is your current approach for pain management at controlling your pain?

E. Moving Around

1. a. What is your main way of moving around indoors?

b. What is your main way of moving around outdoors?

2. In the LAST 3 DAYS, how many days did you go out of the house or building (no matter how short the period)?

◯ No days out, do no usually go out

◯ Did not go out in the last 3 days but usually go out over a 3-day period

◯ 1-2 days

◯ 3 days

3. Distance walked and wheeled

a. What is the farthest distance you walked at one time without sitting down in the last 3 days?

b. What is the farthest distance you wheeled yourself at one time in the last 3 days (includes use of motorized wheelchair/scooter)?

F. Falls

1. Have you fallen or unexpectedly ended up on the floor or ground or other level? Please enter the number of falls in each time period.

	No fall	1 fall	2 or more falls
a. Last 30 days	◯	◯	◯
b. 31-90 days	◯	◯	◯
c. 91-180 days	◯	◯	◯

2. Dose fear of falling limit your activities?

	No	Yes
a. Limit your going outdoors?	◯	◯
b. Concern you when walking in your home?	◯	◯
c. Limit other activities you do?	◯	◯

G. Sleep

1. Have you experienced difficulty falling or staying asleep in the last three days?

- ◯ Never
- ◯ Not in the last three days, but do have the problem
- ◯ One day
- ◯ Two days
- ◯ Everyday

H. Weight loss

1. Did you lose a lot of weight unintentionally and would you say that weight loss was 5% or more in the LAST 30 DAYS , or 10% or more in the LAST 180 DAYS?

◯ No ◯ Yes

I. Activities

1.	1. No difficulty 2. Some difficulty — I would need some help, would do it slowly or I would become fatigued 3. Great difficulty — I could do little or none of the activity myself
a. Meal preparation In the last three days, if you had to do this by yourself, how able would you be to prepare your meals? This includes planning meals, assembling ingredients, cooking, setting out food and utensils.	No Difficulty Some Difficulty Great Difficulty
b. Ordinary housework In the last three days, if you had to do this by yourself, how able would you be to do ordinary work around the house? Examples include doing dishes, dusting, making bed, tidying up, and laundry.	No Difficulty Some Difficulty Great Difficulty
c. Managing finances In the last three days, if you had to do this by yourself, how able would you be to manage your finances? Examples include paying bills, balancing cheque book, budgeting household expenses, monitoring your credit card.	No Difficulty Some Difficulty Great Difficulty
d. Managing medications In the last three days, if you had to do this by yourself, how able would you be to manage your medications? Examples include remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments.	No Difficulty Some Difficulty Great Difficulty
e. Phone Use In the last three days, if you had to do this by yourself, how able would you be to make or receive telephone calls (with assistive devices such as large numbers on telephone, amplification as needed)?	No Difficulty Some Difficulty Great Difficulty
f. Stairs In the last three days, if you had to do this by yourself, how able would you be to go up and down a full flight of stairs (12-14 stairs)?	No Difficulty Some Difficulty Great Difficulty
g. Shopping In the last three days, if you had to do this by yourself, how able would you be to shop for food and household items without any help (exclude transportation to and from shopping)? Examples include selecting items, paying money.	No Difficulty Some Difficulty Great Difficulty
h. Transportation In the last three days, if you had to do this by yourself, how able would you be to travel by public transportation (navigating system, paying fare) or drive yourself (including getting out of the house, into and out of vehicles) without any help?	No Difficulty Some Difficulty Great Difficulty

2. Bathing

In the last three days, how did you take a bath or shower?

Examples include getting in and out of the tub or shower and washing your full body.

◯	**Independent**— I always did it all by myself without monitoring or help from others
◯	**Independent, set-up help only**—I did it by myself, but others set up the articles or devices I used
◯	**Supervision (Monitoring?)** — I did it by myself, but others watched over me in case I needed more help
◯	**Limited assistance**—I did most of it myself with a bit of physical help from others
◯	**Extensive assistance**—I did most of it myself, but others supported my weight while I did it
◯	**Maximal assistance**— Two or more people supported my weight – OR – others did most of the task for me
◯	**Total dependence**— Others always did all of this for me
◯	Activity did not occur in the last 3 days

J. Fatigue or Tiredness

1. In the last three days, have you felt fatigued? (response options deleted)

K. Shortness of Breath

1. In the last three days, have you had shortness of breath? (response options deleted)

L. Health Conditions

1. Do you have any of the following health conditions or symptoms?

	Not present	Present but not in last 3 days	Once in last 3 days	Twice in last 3 days	Every day in last 3 days
a. Dizziness		◯	◯	◯	◯
b. Unsteady walking		◯	◯	◯	◯
c. Chest pain		◯	◯	◯	◯
d. Difficulty swallowing		◯	◯	◯	◯
e. Difficulty chewing		◯	◯	◯	◯

M. Communication

1. In the last 3 days have you had any difficulties having a conversation – either making yourself understood or understanding others?

◯ No

◯ Yes

2. How would you rate your hearing (with hearing aid, if you use one)?

◯ Good, no problem

◯ Occasionally challenging

◯ Very frustrating, difficult to hear in most situations

N. Vision

1. How would you rate your vision (with glasses if you use them)? (response options deleted)

O. Mood

1. **In the last three days, how often have you felt…**

	Not in the last 3 days	Not in the last 3 days but often feel that way	In 1-2 of the last 3 days	Daily in the last 3 days
a. Little interest or pleasure in things you normally enjoy	◯	◯	◯	◯
b. Anxious, restless or uneasy	◯	◯	◯	◯
c. Sad, depressed, or hopeless?	◯	◯	◯	◯
d. Angry with yourself or others	◯	◯	◯	◯

P. Memory

1. **How would you rate your memory?**
   (response options deleted)

Q. Completing this form

1. **Has anyone helped you complete this form?**

◯ No ◯ Yes

R. Answer this question when you are at the end of your therapy program

1. **Did you complete your goals (response items removed)**

Community Rehab Assessment
In-Clinic Assessment

A. Assessment Type

1. What type of assessment is this (admission or discharge)?

B. Main Problem/Reason for Seeking Outpatient/Ambulatory Rehabilitative Care Services

Referring to Appendix A for a list of 'Main Problems', what do you identify as the primary and secondary 'Main Problem/Reason For Seeking Outpatient/Ambulatory Rehabilitative Care Services':

The following represents a sampling of items. Many have had response options deleted to accommodate posting on the Rehab Alliance Website.

C. Instrumental Activities of Daily Living

Please complete this section, Instrumental Activities of Daily Living for all patients. When answering the questions in this section, consider a 3 day time frame. Section I 1 a-h of the self-report can provide a starting point for a conversation on IADL capacity.

Functional Status	Score
Instrumental Activities of Daily Living **(instructions and response options deleted)**	Capacity
a. Meal Preparation – How Meals are prepared (e.g. planning meals, assembling ingredients, cooking, setting out food and utensils)	
b. Ordinary Housework – How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up, laundry)	
c. Managing Finances – How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored	
d. Managing Medications – How medications are managed (e.g. remembering to take medications, opening bottles, taking correct dosages, giving injections, applying ointments)	
e. Phone Use – How telephone call are made or received (with assistive devise such as large numbers on phone, amplification as needed)	
f. Stairs – How full flight of stairs (12-14 stairs) is managed	
g. Shopping – How shopping is performed for food and household items (e.g. Selecting items, paying money) EXCLUDE TRANSPORTATION	
h. Transportation – How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicle)	

D. Basic Activities of Daily Living

Functional Status	
Basic activities of Daily Living • (**instructions and response options deleted)**	
a. **Bathing -** How takes a full-body bath/shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR	
b. **Personal Hygiene** - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS	
c. **Dressing Upper Body** – How dresses and undresses (street clothes, underwear) above the waist including prosthesis. orthotics, fasteners, pullovers etc.	
d. **Dressing Lower Body** - How dresses and undresses (street clothes, underwear) from the waist down including prosthesis. orthotics, fasteners, pullovers etc.	
e. **Transfer Toilet*** - How moves on and off toilet or commode	
f. **Toilet Use* -** How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes – EXCLUDES TRANSFER ON AND OFF TOILET	
g. **Bed Mobility*** - How moves to and from lying position, turns from side to side, and positions body while in bed	
h. **Eating* -** How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).	

E Gait Speed

1. Timed 4-meter/13 foot walk (Gait Speed) –

F. Communication (response options deleted)

a. Making Self Understood - Expressing information content (both verbal and non-verbal)

b. Ability to Understand Others (Comprehension) – Understanding verbal Information content (however able with hearing appliance normally used)

c. Having a conversation - initiating, taking turns with talking, finishing the conversation and the relevancy of the content of the conversation. This may also include specific difficulty when more than one person is part of the conversation or when the person is fatigued.

d. Speech clarity

G. Visual fatigue and Attention (response categories deleted)

1. VISUAL FATIGUE WHEN PERFORMING DAY-TO-DAY VISUAL TASKS
Effect of visual weariness (from ocular, muscular or cognitive causes) on ability to complete normal day-to-day visual activities (e.g., reading, computer use, watching television) in adequate light (with glasses or with other visual appliance normally used).

2. ADAPTATION TO ADVERSE LISTENING CONDITIONS
Person has difficulty in adapting to situations that disrupt hearing abilities resulting in loss of information.

H. Cognition (response options deleted)

1. Cognitive skills for daily decision making *Making decisions regarding tasks of daily life - e.g., when to get up or have meals, which clothes to wear or activities to do*

2. Memory/Recall Ability

Code for recall of what was learned or known

a. Short-term memory OK – Seems / appears to recall after 5 minutes

b. Procedural memory OK – Can perform all or almost all steps in a multitask sequence without cues

I. In-Home Care

Complete Section I, Questions 1 and 2 if the patient:

- receives formal in home services

OR

- requires substantial assistance with ADL and IADL tasks as per Section C and D above

1. FORMAL IN-HOME CARE	# of Days
Record the number of days that the patient has received in-home care in the LAST 7 DAYS involving:	
a. Personal Support Worker (Home health aides and homemaking services)	
b. Home nurse	
c. Meals	

2. Hours of Informal Care / Active Monitoring During Last 3 Days

Record the total number of hours of help received in the last three days from all family, friends and neighbors for instrumental and personal activities of daily living: _____

J. Additional Optional Measures

1. Additional optional measures

If you choose to further assess your patient's function at admission and discharge using one of the following tools, please record the summary score at admission and discharge:

K. Treatment details

Complete this question only at the end of the treatment program AND if you aren't already collecting this data in NACRS Clinic Lite

1. Treatment details:

a) Date of admission (DD/MMM/YYYY) _____ (e.g., 01/JAN/16)

b) Date of discharge (DD/MMM/YYYY) _____ (e.g., 01/JAN/16)

c) During this episode of care, how many times did this patient visit with each of the following healthcare professions?

Clinician	# visits		Clinician	# visits
Physiotherapist			Occupational Therapy Assistant	
Occupational Therapist			Physiotherapy Assistant	
Speech Language Pathologist			Communications Disorders Assistant	
Registered Practical Nurse			Social Worker	
Registered Nurse			Kinesiologist	