

Local Health Integration Networks

# *Provincial Referral Standards Reference Guide*

**Acute Care to Bedded Levels of Rehabilitative Care & Complex Continuing Care**

May 2018

Updated by the Rehabilitative Care Alliance

## **Introduction**

The Provincial Referral Standards (PRS) were originally developed by the Provincial Standards Sustainability Office (now closed) as part of its Alternative Level of Care, Resource Matching and Referral Business Transformation Initiative. They were developed to provide a standardized referral data set for referrals from acute care to inpatient rehabilitation and Complex Continuing Care (CCC) as well as to other discharge destinations. The PRS was originally released in Spring 2014 following province-wide LHIN CEO approval.

In January 2018, the Rehabilitative Care Alliance (RCA) updated the PRS that apply to referrals to inpatient rehabilitation and CCC. This was done to align it with the terminology in the RCA's [Definitions Framework for Bedded Levels of Rehabilitative Care](#). The framework establishes standardized levels of care for bedded (inpatient) rehabilitative care programs and defines eligibility criteria, patient characteristics and the focus and clinical components of each level of rehabilitative care. This clarity supports a common understanding of rehabilitative care among patients, families and referring professionals and creates a foundation to support system and local capacity planning.

This referral reference guide complements the updated PRS to support consistency in the understanding and submission of referral information from acute care to bedded (inpatient) levels of rehabilitative care and Complex Continuing Care (CCC).

## Rehab & CCC Referral Reference Sheet

Referral Destination		
Data Field	Rationale for Requested Information	Other
<p><b>IDENTIFY REFERRAL DESTINATION:</b></p> <p><b><u>Bedded Level of Rehabilitative Care</u></b></p> <p><input type="checkbox"/> Rehabilitation – High Intensity    <input type="checkbox"/> Rehabilitation – Low Intensity</p> <p><input type="checkbox"/> Complex Medical Management- Short Term</p> <p><input type="checkbox"/> Complex Medical Management- Long Term</p> <p><input type="checkbox"/> Activation/Restoration – Hospital based/Other</p> <p><input type="checkbox"/> <b>Activation/Restoration – Convalescent Care (REFER THROUGH HOME &amp; COMMUNITY CARE)</b></p> <p><b><u>Complex Continuing Care (CCC)</u></b></p> <p><input type="checkbox"/> Other programs (specify): _____</p> <p><b>If Faxed Include Number of Pages (Including Cover):</b></p>	<p>Specificity of referral destination is needed to ensure that referral is directed to correct intake location (especially for organizations without centralized intake).</p> <p>For definitions of the Bedded Levels of Rehabilitative Care, see <a href="#">page 20</a>.</p> <p>This will ensure the Rehab or CCC facility receives the full referral including any attachments</p>	
<p><b>Estimated Date of Rehabilitative Care /CCC Readiness: DD/MM/YYYY</b> Estimated date of when the patient will be ready for transition into a Rehab/CCC program</p>		
Patient Details and Demographics		
Data Field	Rationale for Requested Information	Other
Health Card #:	Health card number is required to validate that an individual is entitled to health care services paid by OHIP. (Ministry of Health and Long-Term Care <sup>1</sup> )	
Version Code:	If patient has a version code (not all patients will), this version code is part of the validation process.	
Province Issuing Health Card:	In the event that patient is from out of province, there will be no confusion as to the type of health card and corresponding number.	
No Health Card #: <input type="checkbox"/>	This is required to capture patients who may not have an Ontario Health Card Number, but are entitled to services paid by OHIP (e.g. Veterans, RCMP); or patients being admitted from out of province or country.	
No Version Code: <input type="checkbox"/>	Not all patients will have a version code.	
Surname and Given Name(s):	This is used as a patient identifier.	

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
Home Address, City, Province, Postal Code, Country	This is the address of the patient's home.	<b>Other Information</b> Country is included as Rehab facilities admit out of country patients.
No Known Address: <input type="checkbox"/>	Some patient populations will not have a home address (e.g. homeless, prison population). This information is helpful for the CCACs to know upfront.	
Telephone # ; Alternate Telephone #; No Alternate Telephone # <input type="checkbox"/>	Primary telephone # for Rehab/CCC facility to contact patient; alternate (e.g. cell phone) if patient cannot be reached at primary number; patient may only have a primary telephone #.	
Current Place of Residence (Complete If Different From Current Address)	This will alert the facility to the address where the patient is currently residing (e.g. temporary residence such as relative's home).	
Date of Birth:	Part of the health card validation process; unique patient identifier.	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Patient identifier. May be required for room accommodation.	
Marital Status:		
Patient Speaks/Understands English: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other	To ensure the Rehab/CCC facility is able to converse with patient and identify if an interpreter will be required to have a fulsome understanding of assessments and services required to support the patient needs. Information will also be shared with other HSPs so that they can prepare to meet the patient needs.	<b>Acronym</b> <b>HSPs-</b> Health Service Providers
Primary and Secondary Alternate Contact Person	Primary contact person (other than patient) and/or secondary contact. This may be a legal or non-legal contact. Also used as emergency contact if required.	
Relationship to Patient: <input type="checkbox"/> POA <input type="checkbox"/> SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Describes the role of the primary and secondary contacts as it relates to legal or non-legal decisions of the patient's care. More than one option can be selected at the same time, i.e. "Spouse"	<b>Acronyms and Definitions</b> <b>POA-</b> Power of Attorney <b>SDM-</b> Substitute Decision Maker

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
		<p><b>Spouse</b>-Partnership in marriage, civil union, domestic partnership, common-law.</p> <p><b>Other</b>-Daughter, son, or another individual who plays a social role</p>
Telephone # ; Alternate Telephone #;	Primary and alternate telephone # where contacts can be reached.	
Insurance:  N/A: <input type="checkbox"/>	Insurance number and carrier name. Private insurance required for out of province and out of country patients. Insurance is also required in addition to OHIP for Ontario patients requesting preferred accommodations that are not covered by OHIP. In some situations Insurance is not required thus the N/A field.	<p><b>Specific to CCC</b></p> <p>Co-payment is specific to this pathway. Prior to the CCC application being sent, it is important that a discussion has taken place with the patient or SDM/POA/family to ensure they are aware of their financial responsibilities. (MOHLTC 4)</p>
Program Requested:	Type of Rehab and CCC program the sender is requesting for the patient.	<p><b>Other Information</b></p> <p>Subject matter experts have suggested that a list of programs available and their description would be helpful for completing the referral to ensure patient is assigned to most appropriate program. This information need is currently being addressed by the Rehabilitative Care Alliance as part of their work plan for FY 2013/14. In the interim, if a cluster has an agreed upon list of Rehab and CCC programs/services, they are encouraged to use this list for the initial implementation. Once the Rehabilitative Alliance provides the province with the standard list of program and services to be used, the Provincial Referral Standards will be refreshed to include this information.</p>

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
Current Location Name:	Location of the Hospital where the patient currently is residing. To identify where the patient is located and can be contacted.	
Current Location Address; City; Province, Postal Code	Contact information for the Hospital where the patient is currently residing. To identify where the patient is located and can be contacted.	
Current Location Contact Number:	Contact number for the Hospital unit where the patient is currently residing, in the event that the receiving facility requires further information related to the patient.	
Bed Offer Contact ( Name and Number):	Contact number for unit staff at the sending facility for notification of bed offer.	

**Medical Information**

Data Field	Rationale for Requested Information	Other
Primary Health Care Provider (e.g. MD, NP)  None: <input type="checkbox"/>	Primary Care Provider that follows the patient in the community. Also important information to be captured since the Provincial initiative of Health Links aims to attach complex patients with Primary Care Providers. If the patient does not have a Primary Care Provider, Social Work or other healthcare professional will assist patient to engage with Health Care Connect.	<b>Acronyms</b> <b>MD-</b> Medical Doctor  <b>NP-</b> Nurse Practitioner
Surname; Given Name(s)	Primary Care Provider's last and first name.	
Reason for Referral:	Example; Patient to return to pre-morbid level of function and/or current multi-system needs.	
Allergies: <input type="checkbox"/> No Known Allergies  <input type="checkbox"/> Yes---If Yes, List	The lack of Allergy information could have devastating impacts on patient safety and care and therefore it is important that the sending facility documents all relevant allergies (Drug, Food, Latex etc.) upfront in the referral process to alert the receiving facility.	

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
Infection Control: <input type="checkbox"/> None <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C. diff <input type="checkbox"/> ESBL <input type="checkbox"/> TB <input type="checkbox"/> Other(Specify)	To alert the receiving facility if the patient requires any Infection Control practices and/or accommodations when providing care (e.g. private room, personal protective equipment).	<b>Acronyms and Definitions</b> <b>None-</b> Patient is negative for the following pathogens and does not require Infection Control practices; if one of the boxes is checked off, patient is considered positive.
		<b>MRSA-</b> Methicillin- resistant Staphylococcus aureus <b>VRE-</b> Vancomycin-resistant Enterococcus <b>C. diff-</b> Clostridium difficile <b>ESBL-</b> Extended-Spectrum Beta-Lactamas-Producing Bacteria <b>TB-</b> Tuberculosis <b>Other-</b> patient may be isolated or may require Infection Control practices related to diarrhea, or symptoms of unknown etiology. (PIDAC, 2013 <sup>2</sup> )
Admission Date: Date of Injury: Surgery Date:	Provides a snapshot of the patient’s journey by providing a timeline from injury to post-op to appropriate program.	
Rehabilitative Care Patient Goals:  CCC (other programs) Patient Goals:	This describes for the receiving facility the goals for care and successful discharge. Goals should be specific, measurable, achievable, realistic and timely.(e.g. Mrs. Smith will feed herself independently with set up in 1 month; Mr. Jones will walk indoors independently without a gait aid in 3 months).	<b>Other Information</b>  Important to note patient goals for both Rehab and CCC depending on the program the patient is being referred to.
Nature/Type of Injury/Event:	Description of injury (e.g. stroke, spinal cord injury, medically complex).	
Primary Diagnosis:	Diagnosis on admission; the condition that motivated the initial hospitalization.	
History of Presenting Illness/Course in Hospital:	Clinical course of patient during hospitalization (e.g. presenting symptoms, infections, surgical complications).	
Current Active Medical Issues/Medical Services following Patient:	Current active medical issues that are being followed by other medical services (e.g. Nephrology, Cardiology).	

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
Past Medical History:	Historical perspective and account of the patient’s past medical needs or crisis. Includes describing any past major illnesses, surgeries, and patient’s health status prior to the presenting problem (e.g. current or ongoing medical conditions such as diabetes).	
Height and Weight:	Required to determine bariatric needs. This information is helpful in identifying if the receiving facility can accommodate the patient.	
Is Patient Currently Receiving Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis Frequency/Days  Location:	To determine if the facility can accommodate/support the treatment on site. To determine if the frequency of the treatments and travel time will not impact the patients ability to participate in the program. Transportation requirements would need to be assessed.	<p><b>Examples</b></p> <p><b>Frequency:</b> e.g. Daily, 3 X weekly</p> <p><b>Days:</b> e.g. M-W-F</p> <p><b>Location:</b> Where treatment will take place (e.g. off-site, on-site)</p>
Data Field	Rationale for Requested Information	Other
Is Patient Currently Receiving Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: Duration:  Location	Refer to Dialysis	<p><b>Examples and Definition</b></p> <p><b>Frequency;</b> How often the patient receives treatments (e.g. daily, weekly, monthly)</p> <p><b>Duration:</b> Length of time required to receive the treatment.</p>
Is Patient Currently Receiving Radiation Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: Duration:  Location:	Refer to Dialysis	Refer to Chemotherapy
Concurrent Treatment Requirements Off-Site: <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Details	Refer to Dialysis	
<p><b>CCC Specific</b> Medical Prognosis</p> <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Palliative <input type="checkbox"/> Unknown Palliative Performance Scale	Prediction of the probable outcome of the course of the disease and/or patient’s health. It was identified that this information is provided by a physician. However, it is important to note that although a physician provides this information, they do not necessarily have to complete the actual referral form to do so.	



Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
	The physician can provide this information through any document, and the person filling out the form (NP, RN or other) can then just transcribe the physician noted information into the referral form.	
Services Consulted: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SW <input type="checkbox"/> Speech and Language Pathology <input type="checkbox"/> Nutrition <input type="checkbox"/> Other	Allied Health Services consulted in the care of the patient during the course of their hospitalization.	<b>Acronyms</b> <b>PT-</b> Physiotherapy <b>OT-</b> Occupational Therapy <b>SW-</b> Social Work
Pending Investigations: <input type="checkbox"/> Yes <input type="checkbox"/> No Details	Scheduled or pending investigations not completed (e.g. MRI) This information may be pertinent in determining patient acceptance and type of program required.	
Frequency of Lab Tests: <input type="checkbox"/> Unknown <input type="checkbox"/> None	Transportation requirements may be needed if lab tests cannot be accommodated on site. Also to determine impact on patient's participation in the program and ability to participate.	

**Respiratory Care Requirements**

Data Field	Rationale for Requested Information	Other	
Does the Patient Have Respiratory Care Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No --- If No Skip to Next Section	This question is intended to prompt the sender to include any respiratory care requirements to ensure the receiving facility has the equipment and staff trained to support the patient. Patients referred to CCC programs often require specialized respiratory care and equipment to support their health.		
Supplemental Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No			Ventilator: <input type="checkbox"/> Yes <input type="checkbox"/> No
Breath Stacking: <input type="checkbox"/> Yes <input type="checkbox"/> No			Insufflation/Exsufflation <input type="checkbox"/> Yes <input type="checkbox"/> No
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cuffed <input type="checkbox"/> Cuffless			

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
Suctioning: <input type="checkbox"/> Yes <input type="checkbox"/> No      Frequency:		<b>Example</b>  <b>Frequency:</b> This describes how often the patient requires suctioning (e.g. hourly, or as required)
C-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No    Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bi-PAP: <input type="checkbox"/> Yes <input type="checkbox"/> No    Rescue Rate: <input type="checkbox"/> Yes <input type="checkbox"/> No  Patient Owned: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional Comments:	Provide any information that has not been shared but is critical to ensure a safe transition to Rehab or CCC.	

**IV Therapy**

Data Field	Rationale for Requested Information	Other
IV in Use: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No skip to Next Section	To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	<b>Acronym</b>  <b>PICC-</b> Peripherally Inserted Central Catheter
IV Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Central Line: <input type="checkbox"/> Yes <input type="checkbox"/> No		
PICC Line: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Swallowing and Nutrition**

Swallowing Deficit: <input type="checkbox"/> Yes <input type="checkbox"/> No	To identify that patient may have special needs related to the swallowing deficit.	
Swallowing Assessment Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, information in report will be of benefit to the receiving facility and will outline plan of care; if No facility may not have	

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requested Information	Other
	the ability to complete assessment on site and may require completion prior to accepting the patient. It is our understanding that any information related to the swallowing assessment is part of the speech pathology reports under (other consultative reports section) of the referral form.	
Type of Swallowing Assessment and Details:	Information that will help determine best program and care for patient.	
TPN: <input type="checkbox"/> Yes (If Yes, Include Prescription with Referral) <input type="checkbox"/> No	To ensure the receiving facility has the equipment and staff trained to support the patient’s needs. To ensure Pharmacy has the ability to prepare or obtain the solution required.	<b>Acronym</b>  <b>TPN</b> -Total Parenteral Nutrition
Enteral Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No	To ensure the receiving facility has the equipment and staff trained to support the patient’s needs.	

**Skin Condition**

Data Field	Rationale for Requesting Information	Other
Surgical Wounds and/or Other Wounds Ulcers:  <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Skip to next Section	Required to alert receiving facility of required wound care support.  To ensure the receiving facility has the equipment and staff trained to support the patient’s needs.	
Location: _____ Stage: _____	To ensure the receiving facility has the equipment (VAC or Negative Pressure Wound Therapy) and staff trained to support the patient’s needs. Facility may not be able to support wound management care plan.	<b>Definition and Acronym</b>  <b>Location:</b> This is the location of the wound or ulcer on the patient body.
Dressing Type: _____ Frequency: _____  (e.g. Negative Pressure Wound Therapy or VAC)	Frequency and time to complete dressing is required to review impact on the patient’s time to participate in the program.	<b>VAC</b> -Vacuum Dressing <b>Frequency:</b> How often the dressing is changed (e.g. daily, twice daily)

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requesting Information	Other
Time to Complete Dressing: <input type="checkbox"/> Less Than 30 Minutes <input type="checkbox"/> Greater Than 30 Minutes		
<i>* If additional wounds exist, add supplementary information on a separate sheet of paper.</i>	Supplementary information can be part of the attachments included with the referral.	

**Continance**

Data Field	Rationale for Requesting Information	Other
Is Patient Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If Yes, Skip to Next Section	Required for patient care planning.	
Bladder Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent		
Bowel Continent: <input type="checkbox"/> Yes <input type="checkbox"/> No If No: <input type="checkbox"/> Occasional Incontinence <input type="checkbox"/> Incontinent		

**Pain Care Requirements**

Data Field	Rationale for Information	Other
Does the Patient Have a Pain Management Strategy: <input type="checkbox"/> Yes <input type="checkbox"/> No ---If No, Skip to Next Section	Patient's ability to participate successfully in a program is dependent upon controlled pain. Receiving facility may request pain management plan prior to accepting patient.	
Controlled With Oral Analgesics: <input type="checkbox"/> Yes <input type="checkbox"/> No	This information will provide the facility with the type of care needs required to support the patient.	
Medication Pump: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Epidural: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Information	Other
Has a Pain Plan of Care Been Started: <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's ability to participate successfully in a program is dependent upon controlled pain.	
<b>Communication</b>		
Data Field	Rationale for Information	Other
Does the Patient Have a Communication Impairment:  <input type="checkbox"/> Yes <input type="checkbox"/> No ---If No, Skip to Next Section	This information will provide the facility with the type of care needs required to support the patient.	
Communication Impairment Description:	Describe the type of communication impairment (e.g. Aphasia, articulation problems).	
<b>Cognition</b>		
Data Field	Rationale for Information	Other
Cognitive Impairment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Assess---If No, or Unable to Assess, Skip to Next Section	Required to understand if patient's cognition will impair ability to participate in the program. The type of cognitive impairment will determine the appropriate Rehab or CCC program  Delirium can be attributed to several things (e.g. Chronic condition; infection, medications, surgery and drug/alcohol abuse). This will be important information for the receiving facility when determining the appropriate program for the patient.	
Details on Cognitive Deficits:		
Has the Patient Shown the Ability to Learn and Retain Information: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Details:		
Delirium: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If Yes, Cause/ Details:		
History of Diagnosed Dementia: <input type="checkbox"/> Yes <input type="checkbox"/> No	People with dementia require skilled interventions in a controlled environment. The receiving facility will want to ensure they can support this type of patient safely.	
<b>Behaviour</b>		
Data Field	Rationale for Information	Other
Are There Behavioural Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Skip to Next Section Does the Patient Have a Behaviour Management Strategy: <input type="checkbox"/> Yes <input type="checkbox"/> No	People with challenging behaviours require skilled interventions in a controlled environment. The receiving facility will want to ensure they can support the patient safely. This includes the	

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Information	Other
Behaviour: <input type="checkbox"/> Need for Constant Observation <input type="checkbox"/> Verbal Aggression <input type="checkbox"/> Physical Aggression <input type="checkbox"/> Agitation <input type="checkbox"/> Wandering <input type="checkbox"/> Sundowning <input type="checkbox"/> Exit-Seeking <input type="checkbox"/> Resisting Care <input type="checkbox"/> Other <input type="checkbox"/> Restraints---If Yes, Type/Frequency Details:	facility having the type of environment that the patient requires (e.g. secure unit).	
Level of Security: <input type="checkbox"/> Non-Secure Unit <input type="checkbox"/> Secure Unit  <input type="checkbox"/> Wander Guard <input type="checkbox"/> One-to-one.		

**Social History**

Data Field	Rationale for Requesting Information	Other
Discharge Destination: <input type="checkbox"/> Multi-Storey <input type="checkbox"/> Bungalow <input type="checkbox"/> Apartment <input type="checkbox"/> LTC <input type="checkbox"/> Retirement Home (Name)	Discharge destination will help to direct patient's Rehab/CCC goals and supporting care plan. If patient does not have a discharge destination in place, work will be required to find a suitable discharge destination; receiving facility may request a repatriation agreement with the sending facility in the event a discharge destination is not found.	
Accommodation Barriers:  <input type="checkbox"/> Unknown	Accommodation barriers that must be dealt with prior to the patient returning home. This becomes part to the patient care plan (e.g. stairs).	
Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Details  Alcohol and/or Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Details	Smoking assessment and care plan may be required as the receiving facility may not be able to support the patient's smoking needs; or drug/alcohol withdrawal needs (e.g. Methadone).	
Previous Community Supports: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Details	Helpful for determining care planning needs.	

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requesting Information	Other
Discharge Planning Post Hospitalization Addressed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Details	To ensure the patient or SDM clearly understands his/her discharge destination and targeted length of stay.	<b>Acronym</b> <b>SDM</b> -Substitute Decision Maker
Discharge Plan Discussed with Patient/SDM:  <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Current Functional Status**

Data Field	Rationale for Requesting Information	Other
Sitting Tolerance: <input type="checkbox"/> More Than 2 Hours Daily <input type="checkbox"/> 1-2 Hours Daily <input type="checkbox"/> Less Than 1 Hour Daily <input type="checkbox"/> Has not Been Up	Patient functional status information will help direct patient to most appropriate program which will enhance patient's independence. Physical tolerance will help the receiver understand the patient's functional ability to participate and direct to the appropriate program (e.g. high tolerance program, low tolerance program).  <p style="text-align: center;"><b>Definitions for Weight Bearing Status</b></p> Full= The patient may place their full body weight on the affected leg when standing or walking  As Tolerated= When walking or standing the patient evenly distributes their weight through their legs and may place only as much weight as feels comfortable on the affected leg. Pain will be the guide for the patient as they feel pain they should place less weight on the affected leg.  Partial= When the patient stands or walks they may place a percentage of the their body weight on the affected leg – this will be at the direction of their physician.	
Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision  <input type="checkbox"/> Assist X1 <input type="checkbox"/> Assist X2 <input type="checkbox"/> Mechanical Lift		
Ambulation: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision  <input type="checkbox"/> Assist X1 <input type="checkbox"/> Assist X2 <input type="checkbox"/> Unable  Number of Meters:		
Weight Bearing Status: <input type="checkbox"/> Full <input type="checkbox"/> As Tolerated  <input type="checkbox"/> Partial <input type="checkbox"/> Toe Touch <input type="checkbox"/> Non		
Bed Mobility: <input type="checkbox"/> Independent <input type="checkbox"/> Supervision  <input type="checkbox"/> Assist X1 <input type="checkbox"/> Assist X2		

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requesting Information	Other
	<p>Toe Touch= When the patient stands or walks they may touch the floor only for balance and do not place actual full weight on their affected leg; almost all of their weight is taken through the arms with the aid of a walker or crutches.</p> <p>Non= The patient cannot place any weight on their affected leg. Do not touch the floor with the affected leg. While standing or walking they must hold their affected leg off the floor.</p> <p>Reference: Thunder Bay Regional Health Sciences, Total Joint Clinical Pathway Team 2008. Retrieved from <a href="http://www.tbrhsc.net/site_wide_references/surgical_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20(Restricted%20Weight%20Bearing).pdf">http://www.tbrhsc.net/site_wide_references/surgical_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20(Restricted%20Weight%20Bearing).pdf</a></p>	

**Activities of Daily Living**

Data Field	Rationale for Requesting Information	Other
<p>Level of Function Prior to Hospital Admission (ADL &amp; IADL)</p> <p><i>Current Status Table-Complete the Table Below</i></p>	<p>To have an understanding of the patients premorbid level of functioning and a baseline to gauge the patient's progress.</p>	<p><b>Acronyms</b></p> <p><b>ADL</b>-Activities of Daily Living</p> <p><b>IADL</b>-Instrumental Activities of Daily Living</p>



Rehab & CCC Referral Reference Sheet Continued

Data Field							Rationale for Requesting Information	Other
Activity	Independent	Cueing/ Set/ Up or Supervision	Min. Assist	Mod. Assist	Max Assist	Total Care	<p>To understand patients current functional status and ability to perform activities of daily living independently.</p> <p><b>Other Information</b> Currently there are no standardized assessment tools for the Rehab and CCC programs. There are no common definitions used across the province that define:</p> <ul style="list-style-type: none"> <li>Independent; Cueing/Setup or Supervision; Minimum Assist; Moderate Assist; Maximum Assist; Total Care.</li> </ul>	<p><i>Across the province sites are using either the RAI HC-ADL Self-Performance<sup>6</sup> ; the AlphaFIM<sup>®7</sup>- levels of function description and ratings or other Health Service Provider assessment tools or criteria for completing the ADL section. For the Initial Implementation the Provincial Delivery and Project Sponsor will collect feedback on the use of existing resources leveraged by the participating sites to complete the ADL section. In addition we will be adding specific questions in our Rehab and CCC evaluation surveys to help with the assessment of the ADL section. For your reference Appendix D and E provides the definitions from the RAI HC and the AlphaFIM<sup>®</sup></i></p>
Eating								
Grooming								
Dressing								
Dressing								
Toileting								
Bathing								

Special Equipment Needs		
Data Field	Rationale for Requesting Information	Other
Special Equipment Required: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Skip to next Section <input type="checkbox"/> Halo <input type="checkbox"/> Orthosis <input type="checkbox"/> Bariatric <input type="checkbox"/> Other Pleuracentesis: <input type="checkbox"/> Yes <input type="checkbox"/> No Paracenteisis : <input type="checkbox"/> Yes <input type="checkbox"/> No Need for Special Mattress: Yes/No Negative Pressure Wound Therapy: Yes/No	To ensure the receiving facility has the equipment and staff trained to support the patient's needs.	

Rehab & CCC Referral Reference Sheet Continued

**Rehab Specific**  
**AlphaFIM® Instrument**

AlphaFIM® Data Available: <input type="checkbox"/> Yes <input type="checkbox"/> No--- If No, Skip to Next Section				AlphaFIM® provides a consistent method of assessing patient disability and functional status in the acute care setting. The Alpha-FIM® instrument helps clinicians to obtain expected FIM® ratings, evaluate expected discharge status, and project expected minutes of care. These ratings can then be used to assign a probable discharge disposition from the acute care setting and can be converted into expected minutes of patient care, which help staff and family members understand the patient’s resource needs for performing activities of daily living (Uniform Data System for Medical Rehabilitation <sup>5</sup> ).	Trademark/Copyright notice added at bottom of last page of Rehab/CCC referral as requested by UDSMR :  “AlphaFIM and FIM are trademarks of Uniform Data System for Medical Rehabilitation (UDSMR), a division of UB Foundation Activities, Inc. All Rights Reserved. The AlphaFIM items contained herein are the property of UDSMR and are reprinted with permission.”
Has the Patient Been Observed Walking 150 Feet or More: <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes- Raw Ratings(rate levels 1-7):	Transfers: Bed, Chair	Expression	Transfers: Toilet		
	Bowel Management	Locomotion: Walk	Memory		
If No- Raw Ratings(rate levels 1-7):	Eating	Expression	Transfers: Toilet		
	Bowel Management	Grooming	Memory		
Projected:	FIM® projected Raw Motor(13)	FIM® projected Cognitive (5)		AlphaFIM® results provided with the Rehab and CCC Provincial Referral Standards will be provided by those health service providers who are trained and licenced to use this instrument.	
	Help Needed				

**Attachments**

Data Field	Rationale for Requesting Information	Other
Details on other relevant information that would assist with this referral:	Any pertinent information specific to the patient that might not have been captured in the referral but will help the receiver with their decision making process and patient care planning.	
Please Include with this Referral:  <input type="checkbox"/> Admission History and Physical  <input type="checkbox"/> Relevant Assessments (Behavioural, PT, OT, SLP, SW, Nursing, Physician)	These attachments were deemed necessary by Subject Matter Experts as required information to make an accept decision into the Rehab or CCC program.	<b>Acronyms</b>  <b>PT</b> -Physiotherapy <b>OT</b> - Occupational Therapy <b>SLP</b> - Speech Language and Pathology <b>SW</b> - Social Work <b>US</b> -Ultra Sound

Rehab & CCC Referral Reference Sheet Continued

Data Field	Rationale for Requesting Information	Other
<input type="checkbox"/> All Relevant Diagnostic Imaging Results (CT Scan, MRI, X-Ray, US, etc.)  <input type="checkbox"/> 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; Contact Number; Direct Unit Phone Number.	The person completing the referral must be identified in the event that the receiving facility requires follow-up information related to the patient and referral. Contact # and direct unit phone provides the facility with specific line to call.	
If Faxed Include Number or Pages (Including Cover)	This will ensure that the Rehab or CCC referral is received in full and that no information is missing.	



## Key Features of the Bedded Levels of Rehabilitative Care

For full descriptions of each level, see:

Rehabilitative Care Alliance Definitions Framework for Bedded Levels of Rehabilitative Care available at <http://rehabcarealliance.ca/definitions-1>

Rehabilitation	Activation/Restoration	Short-Term Complex Medical Management	Long-Term Complex Medical Management
<p><b>Functional Goal:</b> <u>Progression</u>  <i>Time-limited, coordinated interprofessional rehabilitation plan of care ranging from low to high intensity through a combined and coordinated use of medical, nursing and allied health professional skills.</i></p> <p><b>Target Population:</b> Medically stable, able to participate in comprehensive rehabilitation program</p> <p><b>Average LOS:</b> &lt;90 Days. Based on best practice targets and discharge indicator considerations. Rehab team to confirm LOS for specific program.</p> <p><b>Discharge Indicator:</b> Rehab goals met, access to MD/nursing care no longer required</p> <p><b>Medical Care:</b> Daily physician access</p> <p><b>Nursing Care:</b> Up to 3 hrs/day. Some may go up to 4 hrs.</p> <p><b>Therapy Care:</b> Direct care by regulated health professionals and as assigned to non-regulated professionals</p> <p><b>Therapy Intensity:</b> 15-30 mins of therapy 3x/day to 3 hrs/day. Based on patient's tolerance.</p>	<p><b>Functional Goal:</b> <u>Progression</u>  <i>Exercise and recreational activities offered to increase strength and independence. Goal achievement does not require daily access to a full interprofessional rehabilitation team &amp; coordinated team approach.</i></p> <p><b>Target Population:</b> Medically stable, cognitively and physically able to participate in restorative activities</p> <p><b>Average LOS:</b> (56-72 days) &lt;90 Days</p> <p><b>Discharge Indicator:</b> Rehab goals met, access to MD/nursing care no longer required</p> <p><b>Medical Care:</b> Weekly physician access/follow-up</p> <p><b>Nursing Care:</b> &lt;2 hrs/day</p> <p><b>Therapy Care:</b> Consulted by regulated health professionals, delivered mostly by non-regulated professional as assigned</p> <p><b>Therapy Intensity:</b> Group or 1:1 setting, throughout the day 30 mins or up to 2 hrs/day (5-7 days/week).</p>	<p><b>Functional Goal:</b>  <u>Stabilization &amp; Progression</u>  <i>Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.</i></p> <p><b>Target Population:</b> Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support. On admission, may have limited physical and/or cognitive capacity due to medical complexity but believed to have restorative potential.</p> <p><b>Average LOS:</b> Up to 90 Days  <b>Discharge Indicator:</b> Medical/functional recovery to allow patient to safely transition to next level of rehab care or alternate environment</p> <p><b>Medical care:</b> Access to scheduled physician care/daily medical oversight  <b>Nursing Care:</b> &gt;3hrs /day  <b>Therapy Care:</b> Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professionals as assigned.  <b>Therapy Intensity:</b> Up to 1 hr, as tolerated by the patient</p>	<p><b>Functional Goal:</b> <u>Maintenance</u>  <i>Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function</i></p> <p><b>Target Population:</b> Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support that cannot be met at home or in a LTCH</p> <p><b>Average LOS:</b> Will remain at this level</p> <p><b>Discharge Indicator:</b> Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes</p> <p><b>Medical care:</b> Access to weekly physician follow up/oversight – up to 8 monitoring visits per month  <b>Nursing Care:</b> &gt;3hrs /day  <b>Therapy Care:</b> Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professional as assigned.  <b>Therapy Intensity:</b> Regulated health professional available to maintain and optimize functional abilities.</p>

## Appendix E- The AlphaFIM® Levels of Function: Description and Ratings

The following has been retrieved from the AlphaFIM® Instrument Guide, Version 4.01, 2009 (p.10).

<b>No Helper</b>	The Patient performs all tasks without assistance from another person
<b>FIM® 7</b>	<b>Complete Independence:</b> The patient safely performs all tasks without assistance from a helper, without a device, and in a reasonable amount of time.
<b>Modified Independence</b>	
<b>FIM® 6</b>	The patient performs all task without assistance from a helper, and one or more of the following are true: <ul style="list-style-type: none"> <li>• The patient requires an assistive device to perform tasks, and the patient applies the device without any assistance.</li> <li>• The patient requires a prosthesis or orthosis that is necessary for performing tasks, and the patient applies the prosthesis or orthosis without assistance.</li> <li>• The patient takes extra time to perform tasks.</li> <li>• There is concern for the patient’s safety when performs tasks.</li> </ul>
<b>Helper</b>	The patient requires another person (whether for supervision or physical assistance) to perform tasks <u>or</u> the patient does not perform tasks.
<b>Modified Dependence:</b> The patient performs 50 percent or more of tasks.	
<b>FIM® 5</b>	Supervision/Setup: The patient performs all tasks but requires supervision (typically standing by, cueing, or coaxing) or setup (for example, setting out necessary items and helping to apply a prosthesis or orthosis)
<b>FIM® 4</b>	Minimal Assistance: The patient performs 75 percent or more of the tasks, requiring no more help than touching.
<b>FIM® 3</b>	Moderate Assistance: The patient performs 50-74 percent of the tasks, requiring physical assistance beyond touching.
<b>Complete Dependence:</b> The patient performs less than 50 percent of the tasks, requiring maximal or total assistance from a helper	
<b>FIM® 2</b>	Maximal Assistance: The patient performs 25-49 percent of the tasks.
<b>FIM® 1</b>	Total Assistance: One or both of the following are true: <ul style="list-style-type: none"> <li>• The patient performs less than 25 percent of the tasks (including non-performance of tasks).</li> <li>• The patient requires assistance from two helpers to perform tasks.</li> </ul>

## References

1. Ministry of Health of Health and Long-Term Care (MOHLTC). (2012-12-06). Ministry Programs Ontario Health Insurance Plan (OHIP). Retrieved from <http://www.health.gov.on.ca/en/public/programs/ohip/>
2. Provincial Infectious Diseases Advisory Committee (PIDAC). (2013). *Annex A. Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs) in all Health Care Settings*. Retrieved from [http://www.publichealthontario.ca/en/eRepository/PIDAC-IPC\\_Annex\\_A\\_Screening\\_Testing\\_Surveillance\\_AROs\\_2013.pdf](http://www.publichealthontario.ca/en/eRepository/PIDAC-IPC_Annex_A_Screening_Testing_Surveillance_AROs_2013.pdf)
3. College of Nurses of Ontario (CNO). (2011). *Fact Sheet. Legislation and Regulation: An Introduction to the Nursing Act, 1991*. Retrieved from [http://www.cno.org/Global/docs/prac/41064\\_fsNursingact.pdf](http://www.cno.org/Global/docs/prac/41064_fsNursingact.pdf)
4. MOHLTC (2010). *Publications. Complex Continuing Care Co-payment 2010*. Retrieved from <http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx>
5. Uniform Data System for Medical Rehabilitation (2013). *About the Alpha-FIM® System*. Retrieved from [http://www.udsmr.org/WebModules/Alpha/Alp\\_About.aspx](http://www.udsmr.org/WebModules/Alpha/Alp_About.aspx)
6. Hospital MDS-HC Canadian Version (2002).
7. Uniform Data System for Medical Rehabilitation (2009). *The AlphaFIM® Instrument Guide Version 4.01*.
8. Thunder Bay Regional Health Sciences Centre (2008). *Total Hip Replacement Exercise Booklet – Restricted Weight Bearing*. Retrieved from [http://www.tbrhsc.net/site\\_wide\\_references/surgical\\_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20\(Restricted%20Weight%20Bearing\).pdf](http://www.tbrhsc.net/site_wide_references/surgical_booklets/Total%20Hip%20Replacement%20-%20Exercise%20Booklet%20%20(Restricted%20Weight%20Bearing).pdf)