Complex Care & Rehabilitation Application Form

Contact the Home and Community Care Support Services HNHB at **1-800-810-0000 Ext 1713**

** Required Field*

Patient Name* _____ **HCN*** _____ **VC*** _____ **DOB*** dd/mm/yyyy **Gender*** _____
Address* _____ **City*** _____ **Province*** _____ **Postal Code*** _____
Patient Phone* _____ **Height*** _____ **Weight *** _____ **Hospital Admission Date*** dd/mm/yyyy
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*** dd/mm/yyyy

☐ 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** dd/mm/yyyy _____
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.)

Print Clear

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 ClinicalConnect**

Type	Physician / Surgeon	Scheduled Date	Notes
		dd/mm/yyyy	
		dd/mm/yyyy	
		dd/mm/yyyy	
		dd/mm/yyyy	

☐ **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** dd/mm/yyyy
Upper Extremity Right	**Date of Assessment** dd/mm/yyyy
Lower Extremity Left	**Date of Assessment** dd/mm/yyyy
Lower Extremity Right	**Date of Assessment** dd/mm/yyyy

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

Patient Name _____ **HCN** _____

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**_____

Patient Name _____ **HCN** _____

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* dd/mm/yyyy

Patient or Substitute Decision Maker Consent*

The above information has been explained to me by _____ and I have had the opportunity to ask questions about the program and discharge process.

I understand that:

1. The above information will be shared for the purposes of a complex care and/or rehabilitation application
2. These programs are transitional in nature
3. I will transition out of hospital when my complex care/rehabilitation care needs are met or can no longer be met in hospital and a suitable alternate plan has been developed.

_____ _____ _____

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

Applications for Complex Care and Low Intensity Rehabilitation	Applications for High Intensity Rehabilitation Fax to Hospital Programs
Fax to HCCSS HNHB at 1-905-639-6688	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