

Patient Name: \_\_\_\_\_

HCN: \_\_\_\_\_

**Attachment Checklist:**

- Demographic Information
- Letter of Understanding (Consent and Information Letter Provided)
- Relevant Nursing & Allied Notes from the last 7 days, including initial assessment
- Comprehensive history & physical; relevant specialist consults
- Medication Administration Record (to be sent on day of Bed Offer)

**Program:**

- Low Intensity Rehab (WRHN@Chicopee, SJHCG)
- General Rehab (WRHN@Chicopee, SJHCG)
- Stroke Rehab (WRHN @Chicopee, SJHCG)
  - Ischemic
  - Hemorrhagic

City where patient lives: \_\_\_\_\_

SDM name &amp; Contact Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Weight Bearing Status / Restrictions/ Activity

Orders: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

History of Present Illness/Surgery:

Follow-Up Appointments/Imaging: \_\_\_\_\_

**ADL Function (B - Baseline, C - Current)**

Ind = Independent

SU = Setup Only

S = Supervision

A = Assistance (1x, 2x etc.)

	Ind	SU	S	A	Demonstrated Progress	Goals for Discharge
Feeding						
Grooming						
Dressing						
Toileting						
Bathing						

**Function (B - Baseline, C - Current)**

Ind = Independent

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	Ind	SU	S	A	Demonstrated Progress	Goals for Discharge
Bed Mobility						
Bed < ~ > Chair						
Ambulation						
Stairs						
Equipment needs						
Speech, Swallow						
Cognition						
Current & Goals						

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**CLINICAL INFORMATION**

Code Status: \_\_\_\_\_

Allergies:  No  Yes: \_\_\_\_\_

Isolation Status:  Clear

Contact: \_\_\_\_\_  Droplet: \_\_\_\_\_

Responsive Behaviours:  No  Yes

Bed/Chair Alarm:  No  Yes  Both

Cytotoxic precautions:  No  Yes

Hearing Impaired:  No  Yes Aids: \_\_\_\_\_

Vision Impaired:  No  Yes Aids: \_\_\_\_\_

Bladder:  Continent  Incontinent:

Catheter:  No  Yes - Change Due: \_\_\_\_\_

Bowel:  Continent  Incontinent Last BM: \_\_\_\_\_

Ostomy:  No  Yes - Level of Independence: \_\_\_\_\_

Diet Type: \_\_\_\_\_

Enteral Feeds:  No  Yes

IV Therapy:  No  Yes - Dosage: \_\_\_\_\_

IV Antibiotics:  No  Yes - Dosage: \_\_\_\_\_

PICC Line:  No  Yes - External Length: \_\_\_\_\_

PICC Insertion Date: \_\_\_\_\_

Skin Condition:  Intact  Wounds - details:  
 \_\_\_\_\_

Dialysis:  No  Yes - Type:  Hemo  PD

Dialysis schedule: \_\_\_\_\_

Chemo/Rad:  No  Yes (if yes, provide schedule)

Supplemental Oxygen:  No  Yes - L/min: \_\_\_\_\_

Home O2:  No  Yes - L/min: \_\_\_\_\_

CPAP:  No  Yes - level of independence: \_\_\_\_\_

**If trach in situ, please provide details in an attachment**

**DISCHARGE PLAN AND ANY SOCIAL CONSIDERATIONS**

Pre-admission home setup (e.g. bungalow, 2 steps to enter; lives with spouse):

Anticipated discharge destination: \_\_\_\_\_

 Previous Supports:  OHaH: \_\_\_\_\_ Other supports: \_\_\_\_\_

Anticipated discharge barriers: \_\_\_\_\_

**CONTACT INFORMATION**

Bed Offer Unit, Contact Number and Extension:

Contributor	Designation	Contact #	Date

Patient Name: _____
HCN: _____

### LETTER OF UNDERSTANDING

\_\_\_\_\_ (Insert patient's name), your current care needs no longer require an acute hospital setting. The health care team has assessed that your needs may be met within the services offered in a rehabilitation program. These programs are regional, offered at multiple sites within WaterlooWellington:

- General Rehabilitation
- Stroke Rehabilitation
- Low Intensity Rehabilitation

Site	General Rehab	Stroke Rehab	Low Intensity Rehab
Waterloo Regional Health Network @Chicopee in Kitchener	✓	✓	✓
St. Joseph's Health Centre Guelph	✓	✓	✓

You will be notified by your health care team when a bed becomes available for you. The first available bed may be located at any one of the locations listed above. The health care team will assist you in arranging the transfer to the accepting rehabilitation program.

Referrals are coordinated by Ontario Health atHome Waterloo Wellington. Your health care team will be sharing your medical and personal information with Ontario Health atHome WW and the rehabilitative care program. Ontario Health atHome WW will add your name to the waiting list. Your initials and gender will be accessible to Ontario Health atHome WW's other hospital partners.

I have discussed my rehabilitation goals and anticipated discharge destination with my care team and understand the above information. I agree to proceed with the referral for the rehabilitative care program.

Patient Name: \_\_\_\_\_

Patient/Substitute Decision Maker's (SDM) Signature: \_\_\_\_\_

Print SDM Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Verbal / telephone agreement Documentation (if signature not possible)**

Consent Obtained From: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Staff Member: \_\_\_\_\_

Printed Name of Staff Member obtaining consent: \_\_\_\_\_