VCH/PHC Inpatient Rehab and CAMU Application Form

Providence HEALTH CARE | Vancouver Coastal Health — Promoting wellness. Ensuring care.

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 **(CAMU)**
FAX: 604-822-7499

Addressograph

Referring Physician:	**Contact number:**	**Today's Date:**
Primary Diagnosis: **Other Medical Concerns:**		**Date of Onset:**
Client's Home Address:		

REFERRAL SITE & FUNDING INFORMATION

Referring Hospital:_________________________ **Unit:**__________________ **Contact Number:**_______________

Unit Contact: Name ________________________ **Role:** ☐ CML ☐ CNL ☐ Other:________________________________

Funding: ☐ MSP ☐ Non-BC ☐ PWD ☐ Extended Benefits ☐ Worksafe Claim #:______________________________
☐ Other:___________________________________

PRE-ADMISSION FUNCTIONAL STATUS

ADLs: ☐ Independent **IADLs:** ☐ Independent
Mobility: ☐ Independent
If impaired, please describe:________________________

____
☐ History of mental health issues ☐ History of substance use

Living situation: ☐ Alone ☐ With others ☐ Facility
☐ Other:____________________________________
Is the home accessible? ☐ Yes ☐ No
Support available: ☐ None ☐ Family ☐ Caregivers
☐ Community ☐ Other:________________________

Employment:
☐ Not employed ☐ Self-employed
☐ Employed as: _____________________________

Planned discharge destination: ☐ Home alone
☐ Home with family ☐ Supportive housing ☐ Long Term Care
☐ Return to sending facility ☐ No plan

CLINICAL INFORMATION

Infection Control: ☐ None
☐ MRSA ☐ COVID-19 ☐ CPO ☐ VRE
☐ C-difficile ☐ Other:____________

Allergies: ☐ None Known ☐ Yes:
List: ______________________

Alpha FIM *(Stroke only)*:__________
Date completed:________________
AIS *(Spine only)*:______________
Date completed:________________

Medical Stability:
☐ Baseline set of vitals (within last 48 hours)
BP:______ T:_______ O_2 Sat:_______
P:______ R:_______
☐ Pain controlled
☐ Recent lab results attached
☐ Recent fevers
Pending Investigation/Procedures:

____

____
Code Status:______________________

Please attach the following documentation if available (for last 5 days where applicable): *Not required for Cerner sites*
☐ Rehab Consult ☐ Discharge summary
☐ Progress notes *(physician, nursing, allied)*
☐ Discipline specific assessments *(OT, PT, SLP, SW, Nutrition, RRT)*
☐ MAR
☐ Labs
☐ Trach form *(if applicable)*
☐ Wound care plan *(if applicable)*
☐ Diabetic record *(if applicable)*
☐ Care facility consent form

Safety behaviours:
☐ No concerns
☐ Violence Risk Alert and Care Plan
☐ Active substance use (drug, alcohol)
☐ Falls Risk ☐ Seizures
☐ Other:____________________

Requires 1:1 supervision:
☐ Yes ☐ No

Communication: Interpreter required: ☐ Yes ☐ No
Primary Language:__________________ ☐ Aphasia ☐ Dysarthria

Nutrition Needs:
☐ Poor intake ☐ Unintentional weight loss ☐ NPO
☐ Regular diet ☐ Diabetes diet ☐ Texture modified:__________ ☐ Other diet:________
☐ Dysphagia diet: ☐ Texture:__________ Fluids: ☐ Thin ☐ Nectar ☐ Honey ☐ Pureed
Feeding tube / type: ☐ Gastrostomy ☐ Gastrojejunal ☐ Jejunostomy ☐ Nasogastric*(by exception only)*
Product:__________________ Schedule:________________
Patient Height:______________ Weight:________________

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CLINICAL INFORMATION *(CON'T)*

Bladder Management:
☐ Continent ☐ Mixed continence
☐ Incontinence
☐ Foley size: ____________
Last Changed: ____________
☐ Intermittent catheter: ____________

Bowel Management:
☐ Continent ☐ Mixed continence
☐ Incontinence ☐ Ostomy
Last bowel movement: ____________

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:
☐ Yes ☐ No
Type: ____________
____

Respiratory needs:
☐ O_2: flow rate: ____________
☐ CPAP/BiPAP
☐ Tracheostomy
Size/Type: ____________
☐ Ventilated
☐ Independent breathing time: ________
☐ MIE *(cough assist machine)*
☐ Suctioning ☐ oral ☐ deep
Frequency: ____________

Special medical needs:
☐ Bariatric needs (greater than 114 kg)
☐ Dialysis (details, days, times):
____
____
☐ IV therapy (note PICC and Hickman lines accepted only at GFS, LGH and CAMU)
☐ PICC ☐ Hickman ☐ Peripheral ☐ IVAD
Line type: ________ Length: ________
Date inserted: ____________
☐ Brace ☐ Orthosis

CURRENT FUNCTIONAL STATUS

Activity Restrictions:
☐ Non WB in: ____________
☐ Partial WB in: ____________
☐ Precautions: ____________
Expected duration: ____________

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 less than 2 hours
☐ Yes ☐ No
Tolerates therapy 2 to 3 hours per day
☐ Yes ☐ No

Mobility: Transfers:
With OT/PT:
☐ Independent ☐ Supervision ☐ Stand By Assist ☐ 1 Person ☐ 2 Person ☐ Lift
With Nursing:
☐ Independent ☐ Supervision ☐ Stand By Assist ☐ 1 Person ☐ 2 Person ☐ Lift
Bed Mobility:
☐ Independent ☐ Supervision ☐ Stand By Assist ☐ 1 Person ☐ 2 Person ☐ Lift
Sitting Balance:
☐ Independent ☐ Supervision ☐ Stand By Assist ☐ 1 Person ☐ 2 Person
Ambulation:
☐ None ☐ Independent ☐ Supervision ☐ Stand By Assist ☐ 1 Person ☐ 2 Person

Mobility/Gait Aid: ____________
Wheelchair: ☐ Manual ☐ Power ☐ Cushion ____________ ☐ Backrest ________
Propulsion method: ☐ Upper Extremity ☐ Hemi propulsion ☐ Foot propulsion
Wheelchair Measurements: Width: ________ Depth: ________ Seat to floor: ________

Body Measurements:
Trochanter to trochanter: ________ PSIS to popliteal fossa: ________ Lower leg length: ________

Activities of daily living:

Grooming:	☐ Independent	☐ Supervision	☐ Stand By Assist	☐ 1 Person	☐ Dependent
Feeding:	☐ Independent	☐ Supervision	☐ Stand By Assist	☐ 1 Person	☐ Dependent
Dressing:	☐ Independent	☐ Supervision	☐ Stand By Assist	☐ 1 Person	☐ Dependent
Toileting:	☐ Independent	☐ Supervision	☐ Stand By Assist	☐ 1 Person	☐ Dependent
Showering:	☐ Independent	☐ Supervision	☐ Stand By Assist	☐ 1 Person	☐ Dependent

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Upcoming/Ongoing appointments: ☐ None

1 ________________________________ **Date:**________________

2 ________________________________ **Date:**________________

3 ________________________________ **Date:**________________

4 ________________________________ **Date:**________________

REHABILITATION GOALS

Patient agrees to attend inpatient rehabilitation: ☐ Yes ☐ No

List functional/realistic rehabilitation goals:

1 ________________________________

____

2 ________________________________

____

3 ________________________________

____

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:

Inpatient Rehab Admissions Guidelines:
http://www.vch.ca/Documents/GF-Strong-inpatient-admission-criteria.pdf

- ☐ Yes, pending bed availability for patient
- ☐ No, pending patient status (follow up required)
- ☐ No, patient declined

Notes:

____

____

____

Form reviewed by:

____

Date of review:

____