Inpatient ABI Referral Guide: What to Include in the Referral Form

This document was developed in collaboration with Bridgepoint Sinai Health System, Toronto Rehab Institute – UHN and West Park Health Care Centre. The purpose of this document is to assist with the completion of the **GTA Rehab Network Integrated Acute Care to Inpatient Rehab and CCC Referral Form** for inpatient ABI rehab.

The content under each referral section below provides suggestions as to what information to include when completing referrals for ABI inpatient rehabilitation. Use this document to assist you in completing the referral form.

Questions? Contact us at 416-597-3057 or at info@abinetwork.ca

REFERRAL SECTIONS

Patient Details and Demographics

- *Ensure there is a valid health card number documented on the referral. If patient is from out of province please provide a photocopy of provincial health card and valid home address. If patient is a private payer, please provide insurance details.*
- *Please provide name and phone number of emergency contact. If possible, please provide name/information for substitute decision maker.*

Medical Information

- *Please document height and weight*
- *If patient is legally blind, please comment if he/she had any supports in place i.e. CNIB*
- *Unable to accommodate patients with dialysis*
- *Date of injury*
- *Trauma versus non trauma*
- *Diagnosis*
- *Please document previous history of relevant surgeries with dates.*
- *Date of surgery/type of surgery and any complications related to surgery*
- *Detailed history of clinical course in hospital*
- *Presence of co-morbidities*
- *Comments around initial imaging/interval imaging*
- *Flag issues which will require monitoring in rehab and identify follow up (will also be described in d/c summary)*

If Oncology patient:

- *Please provide brief description of oncological diagnosis/surgeries/treatment if applicable.*
- *Please describe oncological treatment plan, if applicable.*
- *Please comment on prognosis.*
- *Radiotherapy/Chemotherapy: provide description if applicable*

Respiratory Care Requirements

- *Intermittent oxygen needs are okay. Not able to accommodate constant 02.*
- *Ventilation: Please discuss with service coordinator (case by case basis)*

IV Therapy

- *PICC line okay (no peripheral IV's). For other special lines, please discuss with service coordinator.*

Hearing/Vision

- No suggestions

Swallowing and Nutrition

- *Please provide detail around products/type/frequency.*
- *Please adjust feeding schedule to avoid day time therapy hours i.e. 9am to 3pm.*
- *Not able to accommodate NG.*
- *Comment on textures*
- *Is the patient compliant with the current diet (comments around noncompliance with risk as indicated)?*

Falls

- *Please describe circumstances around falls, frequency of falls, triggers, strategies implemented to reduce falls risk.*

Skin Condition

- *Intact? If not, please provide detail regarding stage, size and treatment*

Continence

- *Ostomy: Please comment on products/type? Please send one week supply of products with patient*

Pain Care Requirements

- No suggestions

Communication

- *Please comment on aphasia/cognition*
- *Is there active engagement?*
- *Does the patient recognize that he/she has deficits? Does the patient have insight into his/her type of problem?*
- *Please comment on any improvements/gains attained.*
- *Please comment on any education provided.*

Cognition

- *Is there a history of dementia, addictions or a psychiatric condition?*

Attention:

- *Specify types of attention*
- *What strategies are being used for success? i.e. modified environment*

Orientation:

- *If patient is aphasic, please indicate if choices were used to determine orientation*

Frustration Tolerance:

- *Please comment on how frustration tolerance impacts your therapeutic session*

Insight:

- *What specifically does the patient have insight into?*
- *What strategies are being used?*
- *If not intact, does the patient understand that he/she has an ABI and that he/she has aspects of cognition which require therapy?*

Memory (Short Term)

- *Please comment on way finding (includes component of carryover)*
- *Are any compensatory strategies being utilized? E.g. memory book*
- *Does the patient recognize the health care provider?*

Carry Over/New Learning [Ability to learn and retain new information, page 6]

- *Please provide examples of carryover i.e. Does the patient remember to apply w/c brakes? Can the pt. use a call bell? Are reminders required? Is the frequency of reminders decreasing?*
- *Is there demonstration of carryover within a session or between sessions?*
- *Does the patient recognize the therapists/nurses on a day to day basis?*
- *List any relative strengths*

Judgment

- *Please comment on falls risk from an OT perspective or any other areas which might be influenced by judgment*

Cognitive Status – Other

- *Comment on strategies utilized for motivating patients*
- *Documentation of other formal assessments*
- *Any problems with initiation?*
- *Comment on motivation vs. mood*
- *During therapeutic session, is a family member participating? Is the family member required to assist with managing behaviours or for interpretation? Is it necessary that the family member be present?*
- *Please list relative strengths*

Behaviour

- *Comment on any pre-existing behaviours which may re-emerge on transition to rehab*

- *Please describe any behaviours in the last 24-48 hours.*
- *Please comment on use of restraints if indicated and behavioural strategies used.*
- *Does the patient require a sitter or has a sitter been utilized in the last 48 hours?*

Social History

- *Smoking: please indicate if patient is a smoker. How often does patient leave unit to smoke? Is supervision required?*
- *What supports can be provided post rehab?*
- *Are the patient and family willing to look into other options for d/c?*
- *Provide information around living arrangements, supports, income, any concerns about social situation, family dynamics*
- *Please provide any information around links to community which were provided to patient and family (as appropriate)*
- *Discussion regarding family overnight stays if appropriate*

Note:

- *Please do not provide any details around LOS at rehab. Instead, please instruct the patient to discuss further with team once in rehab.*
- *Provide patient with preadmission letter once patient has been accepted to ABI.*

Premorbid Details:

- *Please comment on previous home environment, home equipment and services if indicated i.e. CCAC or other supports required prior to admission. What was the patient's previous functional level? If available, please comment on education and prior occupation.*

Current Functional Status

- *Level of assistance required*
- *Why is this level of assistance required? i.e. impaired balance, increased tone, decreased strength, apraxia, motor planning*
- *Is there consistency throughout the day*
- *Is a transfer aid required?*
- *Please ensure information is consistent between type of gait aide utilized both in transfers and mobility*
- *Is the level of assistance/quality of movement fluctuating?*
- *Describe therapeutic transfer (is this different from the routine transfer? i.e. toileting transfer with nursing)*
- *Please comment on type of gait aide being used*
- *If patient has w/c, please provide detail around type and dimensions*
- *Can the patient self-propel their w/c? (if known)*

<u>Ambulation:</u>

- *How is the patient ambulating during therapy?*
- *If the patient has practiced stairs please comment here*
- *During a therapeutic session, is a family member participating? Is the family member required to assist with managing behaviours? Are they required for interpretation? Is it necessary that the family member be present?*

Limbs:

- *Does pain limit tolerance to participation?*
- *Are there any neurological deficits? Mention issues with strength, balance, coordination, tone if any.*
- *What strategies are being used for tone management? i.e. stretching/education*
- *Braces/splinting?*
- *If there are any orthopedic conditions are there any ROM or WB restrictions?*
- *Has the family been provided with education on how to assist with ROM activities?*

Participation:

- *How many sessions do you think the patient can tolerate per day, per week. Expected therapeutic tolerance per session? Keep the following in mind:*
  - *ABI has 2 programs (Regular stream and slow stream).*
  - *Both streams have daily therapy (2-3 sessions per day).*
  - *Regular stream - 45-60 minutes per session.*
  - *Slow stream – 30 minutes per session*

Tolerance

- *How long can the patient sit up in a w/c or regular chair? Please specify if w/c is being used. Assumption would be that a high back chair is being used to assess sitting tolerance unless otherwise mentioned*

Activities of Daily Living

- *Please indicate if able to use call bell (i.e. for toileting)*
- *Further information on toileting and what equipment is this patient using (if known)*

Feeding:

- *Is there evidence of impulsivity? Does the patient require cueing to slow down*
- *Does the patient have difficulty with opening packages?*
- *Use of compensatory strategies/modifications, including tool use*

Special Equipment Needs

- No suggestions

Rehab Specific – Alpha FIM

- No suggestions

Attachments

- *Psychiatric: please provide notes if issues known*