WOODSTOCK HOSPITAL
Woodstock, ON

ACUTE CARE TO REHAB AND COMPLEX CONTINUING CARE (CCC) REFERRAL

PIN NUMBER VISIT NUMBER

PATIENT LAST NAME PATIENT 1ST NAME PATIENT MIDDLE NAME

TELEPHONE

DOB MMM DD YYYY AGE SEX ONT HEALTH CARD NUMBER

FAMILY PHYSICIAN

Identify Referral Destination:

- ☐ Referral to Rehabilitative Care
  - ☐ Rehabilitation
  - ☐ Stroke Rehabilitation
- ☐ Referral to Complex Continuing Care (CCC)
  - ☐ Activation / Restoration
  - ☐ Long Term Medically Complex
  - ☐ Short Term Medically Complex

Please Fax to 519 – 421 – 4221 along with documents not available in Cerner.

Patient Details and Demographics

Health Card Number: _____ Version Code: _____ Province Issuing Health Card: _____
☐ No Health Card Number ☐ No Version Code

Surname: _____ Given Name(s): _____

☐ No Known Address Home Address: _____ City: _____
Province: _____ Postal Code: _____ Country: _____ Telephone: _____
☐ No Alternate Telephone Alternate Telephone: _____

Current Location Name: _____ Current Location Address: _____
City: _____ Province: _____ Postal Code: _____

Current Location Contact Number: _____ Bed Offer Contact (Name): _____ Bed Offer Contact Number: _____

Medical Information

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB
☐ CPE ☐ Other (Specify): _____

Rehab Specific Patient Goals *(Include proposed plans including, discharge plan, discharge destination, discharge care, etc.):*

Weight Bearing Status:
Prosthesis: ☐ Yes ☐ No
☐ Patient and/or family aware of plan and timelines

CCC Specific Patient Goals *(Include proposed plans including, discharge plan, discharge destination, discharge care, etc.):*

☐ Patient and/or family aware of plan and timelines

Is Patient Currently Receiving Dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis
Frequency/Days: _____ Location: _____

Is the Patient Receiving Chemotherapy: Yes No Frequency: _____ Duration: _____
Location: _____

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Services Involved: ☐ PT ☐ OT ☐ SW ☐ SLP ☐ Dietitian ☐ Other:

Respiratory Care Requirements

Does the Patient Have Respiratory Care Requirements? ☐ Yes ☐ No If Yes, explain:

Swallowing and Nutrition

TPN: ☐ Yes (If Yes, Include Prescription with Referral) ☐ No

Enteral Feeds: ☐ Yes ☐ No

Skin Condition

Surgical Wounds and/or Other Wounds, Ulcers: ☐ Yes ☐ No ˇ If Yes, explain:

Date of Injury/Surgery:

Cognition

Has the Patient Shown the Ability to Learn and Retain Information? ☐ Yes ☐ No – If No, explain:

Behaviour

Behaviour: ☐ Need for Constant Observation ☐ Verbal Aggression ☐ Physical Aggression ☐ Agitation
☐ Wandering ☐ Sun Downing ☐ Exit Seeking ☐ Resisting Behaviour
☐ Delerium ☐ Other

☐ Restraints – If Yes, Type/Frequency Details:

Special Equipment Needs

Special Equipment Required: ☐ Yes ☐ No – If No, Skip Section

☐ HALO ☐ Orthosis ☐ Bariatric ☐ Other: _____

Pleuracentesis: ☐ Yes ☐ No Need for Specialized Mattress: ☐ Yes ☐ No

Paracentesis: ☐ Yes ☐ No Negative Pressure Wound Therapy (NPWT): ☐ Yes ☐ No

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Activities of Daily Living

Level of Function Prior to Hospital Admission (ADL & IADL):
Current Status ˇ Complete the Table Below:

Activity	Independent	Cueing/Set–up or Supervision	Minimum Assist	Moderate Assist	Maximum Assist	Total Care
Eating: (Ability to Feed Self)						
Grooming: (Ability to wash face/hands, comb hair, brush teeth)						
Dressing: (Lower body)						
Toileting: (Ability to self–toilet)						
Bathing: (Ability to wash self)						

Attachments

Details on other relevant information that would assist with this referral:

Please Include With This Referral:

- ☐ Admission History and Physical
- ☐ Relevant Assessments (Behavioural, PR, OT, SLP, SW, Nursing, Physician)
- ☐ All Relevant Diagnostic Imaging Results (CT Scan, MRI, X–Ray, US etc.)
- ☐ Relevant Consultation Reports (e.g. Physiotherapy, Occupational Therapy, Speech and Language Pathology and any Psychologist or Psychiatrist Consult Notes if Behaviours are Present
- ☐ For Stroke, Include AlphaFIM