VCH/PHC Inpatient Rehab and CAMU Application Form

Providence Health Care | Vancouver Coastal Health

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:_____

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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Addressograph

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:

_____