HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

Name: ______________________

D.O.B.: __________ (MM/DD/YYYY) __________

APPLICATION TO INPATIENT RESTORATIVE CARE HDGH

This form is designed to be filled out electronically or manually, printed and then faxed to the HDGH Intake office. If completing by hand and limited on space, please include any further information on a separate sheet of paper at the end of the application form.

*Note: Include surname, first name, and date of birth in the top right hand corner of any *additional* pages to be received in the package.

Please mark the program for which you are applying:

☐ **REHABILITATION** ☐ **COMPLEX MEDICAL CARE**

THE FIRST TWO BOXES MUST BE CHECKED TO PROCEED WITH THE APPLICATION

According to HDGH Rehabilitation/Complex Medical Care Application Guidelines:

☐ **Is patient a candidate for Inpatient Rehabilitation/Complex Medical Care?**

- patient has restorative potential, patient's condition likely to benefit from rehab, functional goals established and are SMART goals to support a safe discharge to community, patient/SDM consent and are consistently demonstrating willingness & motivation to participate, 911 & tobacco free campus discussed with patient/SDM

☐ **Is patient Medically Stable?**

- clear diagnosis and co-morbidities have been established, acute medical issues have been addressed, disease processes and/or impairments are not precluding participation in program, vital signs stable, lab values, investigative diagnostics acknowledged and addressed, no undetermined medical issues, medication needs have been determined

INTAKE SERVICES WILL DETERMINE PATIENT READINESS AS DEFINED BELOW:

☐ **Is patient considered ready for Inpatient Rehabilitation/Complex Medical Care?**

- patient meets the criteria of a rehabilitation/complex candidate, patient meets the criteria of medical stability, all medical investigation have been completed, special needs have been determined, patient able to meet minimum tolerance level of rehab program as defined by admission criteria, no behavioural issues limiting patient's ability to participate, no psychiatric issues limiting ability to participate, treatment for other co-morbid conditions does not interfere with patient's ability to participate, discharge options following rehab have been discussed, barriers to discharge post-acute care identified and realistic discharge disposition discussed with patient/family and documented. Stroke diagnosis: alphaFIM completed.

Have you applied to any other Rehabilitation Centre? ☐ Yes ☐ No

If yes, please specify: ______________________________

Date Faxed: ____________________ Contact Person from Sending Site: __________

Signature: ____________________ Date: __________ (MM/DD/YYYY) __________

FINAL Rehab and CCC Provincial Referral Standards for Provincial Implementation March 14, 2014
Alternate Level of Care Resource Matching & Referral Business Transformation Initiative (ALC RM&R BTI)

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ESTD GRACE 1888
HEALTHCARE

APPLICATION TO INPATIENT RESTORATIVE CARE HDGH

Name: ____________________

D.O.B.: ____________ (MM/DD/YYYY)

Identify Application Destination: ☐ Application to Restorative Care
☐ Application to Complex Medical Care (CMC)

If Faxed Include Number of Pages (Including Cover): ____________ Pages

Estimated Date of Rehabilitation/CMC Readiness: ____________ (MM/DD/YYYY)

Patient Details and Demographics

Health Card #: ____________ Version Code: ________ Province Issuing Health Card: ____________

☐ No Health Card # ☐ No Version Code

Surname: ____________ Given Name(s): ____________

☐ No Known Address

Home Address: ____________ City: ____________ Province: ____________

Postal Code: ____________ Country: ____________

Telephone: ____________ Alternate Telephone: ____________ ☐ No Alternate Telephone

Current Place of Residence (Complete if different from home address): ____________

Gender: ☐ Male ☐ Female ☐ Other: ____________ Marital Status: ____________

Patient Speaks/Understands English: ☐ Yes ☐ No Interpreter Required: ☐ Yes ☐ No

Primary Language: ☐ English ☐ French Other: ____________

Primary Alternate Contact Person: ____________

Relationship to Patient (Please check all applicable boxes): ☐ POA ☐ SDM ☐ Spouse Other: ____________

Telephone: ____________ Alternate Telephone: ____________ ☐ No Alternate Telephone

Secondary Alternate Contact Person: ____________

Relationship to Patient (Please check all applicable boxes): ☐ POA ☐ SDM ☐ Spouse Other: ____________

Telephone: ____________ Alternate Telephone: ____________ ☐ No Alternate Telephone

Insurance: ____________ ☐ N/A Program Requested: ____________

Current Location Name: ____________ Current Location Address: ____________

City: ____________ Province: ____________ Postal Code: ____________

Current Location Name: ____________ Bed Offer Contact: ____________

Bed Offer Contact Number: ____________

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ESTD GRACE 1888
HEALTHCARE

Name: ______________________

D.O.B.: ______ (MM/DD/YYYY)

APPLICATION TO INPATIENT RESTORATIVE CARE HDGH

Medical Information

Primary Health Care Provider: Surname: ______________________ Given Name(s): ______________________
(e.g.P MD or NP)

Reason for Referral: ______________________

Allergies: ☐ No Known Allergies ☐ Yes If yes, list allergies: ______________________

Infection Control: ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB

☐ Other (specify) ______________________

Admission Date: ____(MM/DD/YYYY)____ Date of Injury/Event: ____(MM/DD/YYYY)____ Surgery Date: ____(MM/DD/YYYY)____

Rehabilitation Specific Patient Goals: ______________________

____

CMC Specific Goals: ______________________

____

Nature/Type of Injury Event: ______________________

Primary Diagnosis: ______________________

History of Presenting Illness/Course in Hospital: ______________________

____

____

____

____

Current Active Medical Issues/Medical Services Following Patient: ______________________

____

____

____

____

Wound Care: ______________________

Past Medical History: ______________________

____

____

____

Height: ______________cm Weight: ____________kg

Is patient currently receiving dialysis: ☐ Yes ☐ No ☐ Peritoneal ☐ Hemodialysis Frequency/Days: _____

Is patient currently receiving chemotherapy; ☐ Yes ☐ No Frequency: ____________ Duration: ____________

Location: ______________

Signature: ______________________ Date: ______________________