Hôtel-Dieu Grace 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)

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APPLICATION TO INPATIENT RESTORATIVE CARE HDGH

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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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: _____