



Early Stroke Discharge Program Referral

Date of Request: _____ Fax to (902)425-6574

The Early Stroke Discharge team (ESD) is a multidisciplinary team including RecT, SW, OT, PT, Rehabilitation Assistants, SLP, Speech Technician and Dietitian. The ESD services NSH Central Zone team provides intensive rehabilitation in patient's home for a maximum 6 weeks. Must be within **25 km catchment from 1658 Bedford Hwy.**

- Copy of the Acute Stroke/ Neurology Unit Interdisciplinary Assessment faxed with this form
- Copy of the Physicians discharge summary.
- Patient is agreeable intensive rehab in their home (min of 2 hours a day)
- Consult to PM&R ESD clinic completed and faxed with this form (located at the end of this referral).
- Safe home environment (accessible and safe)
- Outstanding investigations:
 - Holter Echo MBS MRI CT Other _____
- Physician's orders for follow up MBS if applicable (please attach the rec with this referral).
- Patient or family email for Virtual care: _____

HPI/Current Diagnosis: _____

Date of Onset: _____ Date of Discharge: _____

Past Medical History: _____

Seizure History: No Yes _____

Substance Use History: No Yes _____

Identified Potential Staff Safety Concerns for Home Visits? No Yes, if yes specify: _____

Discharge Plan: _____

ANTICIPATED ESD REHAB GOAL AREAS – As identified by the patient, family, and/or team:





Part 1: Social History Social Work consulted Social Work not consulted.

Completed by:

Signature: _____

Phone: _____

Print Name: _____

Relationship Status: Single Married Widowed Divorced

Lives: Alone With Spouse Other _____

Capacity Assessed: No Yes _____

Substitute Decision Maker (if applicable) _____

Relationship to Client: Spouse/partner Parent Sibling Son/Daughter Other: _____

Employed at Time of stroke: No Yes

Type and Duration of Employment: _____

Resources/Source of Income: Earnings CPP/Disability Old Age Security STD/LTD Income Assistance

Workplace Pension WCB Employment Insurance Pharmacare

Section "B" Auto Insurance Other: _____

Other Income Information/Applications in Progress: _____

Family/Community Supports (include contact information as appropriate): _____

Continuing Care NS VON Private Care Dept. of Community Services

Mood (adjustment, anxiety, low mood, irritability, low frustration tolerance, etc.; indicate if pre-existing): _____

Reactive Behaviors: No Yes If yes specify below

Physical Aggression Verbal Aggression Self Abuse Inapprop. Sexual Behavior

Known Triggers: _____

Other Behavioral Concerns or Strategies Used: _____

Part 2: Physical Status:





Completed by:

Signature #1: _____

Phone: _____

Signature #2: _____

Phone: _____

Print Name #1: _____

Print Name #2: _____

Activity Tolerance or Restrictions: _____

Transfers (current): Indep SBA/Cueing Min Mod Max Assist

Comments: _____

Ambulation: 1 person SBA Indep Aid: _____

Comments: _____

Balance: BERG Score: _____ Falls: No Yes, if yes Frequency _____

Dizziness: No Yes Comments: _____

Hand Dominance Left Right

Limbs: Strength WNL U/E Impairment Right / Left L/E Impairment Right / Left

ROM WNL U/E Impairment Right / Left L/E Impairment Right / Left

Coordination WNL U/E Impairment Right / Left L/E Impairment Right / Left

Spasticity WNL U/E Impairment Right / Left L/E Impairment Right / Left

Chedoke McMaster Staging: Leg _____ Foot _____ Arm _____ Hand _____

Comments: _____

Present Treatment Program: _____

Home Exercise Programs Provided? No Yes, if yes please attach copies or email to Coordinator

OT: GRASP Level _____ or home GRASP or other HEP _____

PT _____

Part 3: Functional Status:





Completed by:

Signature: _____

Phone: _____

Print Name: _____

Home Environment: Apt _____ Level Home Other _____

____ Steps outside ____ Steps inside ____ Ramp Location of Bedroom: _____ Location of Bathroom: _____

Current ADLs

Dressing	<input type="checkbox"/> Indep	<input type="checkbox"/> SBA/Cueing	<input type="checkbox"/> Assist
Bathing	<input type="checkbox"/> Indep	<input type="checkbox"/> SBA/Cueing	<input type="checkbox"/> Assist
Toileting	<input type="checkbox"/> Indep	<input type="checkbox"/> SBA/Cueing	<input type="checkbox"/> Assist

Support Plan for ADLs _____

Current IADLs

Cooking	I S A D	Grocery Shopping	I S A D	Medication	I S A D
Cleaning	I S A D	Banking	I S A D	Laundry	I S A D

Support Plan for IADLs _____

Transportation Plan: Driving Transit Taxi Friends/Family

Access a Bus- application submitted? No Yes _____

Concerns regarding returning to driving : No Yes: _____

Equipment Recommended or in Place: _____

Cognitive Status:	Not tested	WNL	Affected	Comments or Strategies
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Initiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visuospatial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Part 4: Communication





Completed by:

Signature: _____

Phone: _____

Print Name: _____

Language spoken: _____

Hearing: Intact, can hear routine conversation Intact with hearing aid Completely impaired

Vision: Intact Intact with visual aid Visual field deficit Double vision Completely impaired

Language Expression: Intact Only able to express basic needs Uses gestures Completely impaired

Language Comprehension: Intact Follows Basic Instruction Impaired

Recommended Strategies: _____

Communication Home Program provided _____

Part 5: Nutrition Dietitian consulted Dietitian not consulted

Completed by:

Signature: _____

Phone: _____

Print Name: _____

Current Diet Recommendations: _____

Concerns re: Nutritional Status: _____

Follow up: MBS Other _____

Part 6: Recreation and Leisure CTRS consulted CTRS not consulted.

Completed by:





Signature: _____

Phone: _____

Print Name: _____

Concerns about Leisure, Social and/or Community Engagement: No Yes

Identified Leisure Interests: _____

Possible Barriers to Leisure:

- Transportation Finances Cognition Mood/Initiation
- Physical Abilities Readiness Social Isolation Leisure Awareness

Comments: _____

Follow Up Plans:

- ABI Clinic Family Physician Addiction Services
- Neurovascular Clinic Neurosurgery Vocational Counselling
- Neuropsychology Mental Health Services Ophthalmology
- ABI Day Program NSRAC Driving Program
- Continuing Care – Specify Plan: _____
- Other: _____

Patient is appropriate for ESD team: will see within 72 hours of discharge home

Will see patient for further assessment in next 24 – 48 hours.

Patient is not appropriate for the ESD team and the team will not be seeing them in their home.

ESD coordinator: _____

Date: _____

**Early Supported Stroke Discharge Team
Consultation and Special Examination**





To: PM&R ESD Clinic – Dr. Mountain

Date: _____

Our Findings:

Please see this patient in follow-up in the Early Supported Stroke Discharge Clinic (see Early Supported Discharge Team Referral for further details).

Pertinent other details/considerations for follow-up listed below: None

_____ M.D

_____ Print Name

