Capital Health

Division of Physical Medicine & Rehabilitation

Application for Admission to the Nova Scotia Rehabilitation Centre

Date:_____ (Completed form to be faxed to Rehab Assessor at #473-4460)
(YYYY/MM/DD)

IDENTIFICATION DATA

Last Name:_____ First Name:_____ Male ☐ Female ☐
Health Card No:_____ Version:_____ Date of Birth:____/____/____
Telephone:_____ Family Physician:_____ Phone:_____
Next of Kin: _____ Relationship:_____ Phone:_____

MEDICAL ASSESSMENT: (To be completed by PHYSICIAN)

Current Diagnosis:_____

_____

_____

Date of Onset:_____ Date of Admission:_____

Past Medical History:_____

_____

_____

Surgical Interventions and Dates:_____

_____

Current Findings/Status (Include physical assessment, lab/x-ray results, etc):_____

_____

_____

Height:_____ B/P Range:_____

Weight:_____ HR:_____

Is individual on antibiotics ☐ Yes ☐ No If yes, why:_____
Allergies:_____

_____

Medication Record must be attached to referral

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Rehabilitation Goal(s):_____

_____

_____

_____

Referring Physician Please Note: All clients have a two-week assessment, at the end of which their suitability for continuing in the Rehabilitation Program is determined.

Please sign below to indicate that you will accept the client back to your care if transfer to the referring facility is necessary upon discharge.

Signature:_____, MD

Name:_____

(please print)

Phone contact #:_____

Client consent on page 8 must be signed prior to sending application.

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PART 1: To be completed by PHYSIOTHERAPIST if client is hospitalized at the time of application, otherwise by Physician or Nurse.

Signature: _____ Phone:_____

Print Name:_____

FUNCTIONAL ASSESSMENT

Balance: Berg Score_____

Falls : ☐ No ☐ Yes, if yes Frequency_____

Date of Last Fall_____

Transfers: ☐ Independent ☐ SBA/Cuing

☐ Min/Mod/Max Assist x _____

☐ Mechanical Lift

Comments:_____

Ambulation: ☐ Independent ☐ SBA/Cuing

☐ Min/Mod/Max Assist x _____

☐ Aids_____ ☐ Distance_____

☐ Non-ambulatory

Comments:_____

_____

Limbs: ☐ Normal ☐ U/E Impairment Right / Left

☐ L/E Impairment Right / Left

☐ Impaired coordination

Comments:_____

_____

Spasticity: ☐ No ☐ Yes Describe:_____

_____

Weight Bearing Status/Activity Restrictions:

_____

_____

Present Treatment Program:

_____

_____

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PART 2: To be completed by OCCUPATIONAL THERAPIST if the client is hospitalized at the time of application, otherwise by Physician or Nurse.

Signature: _____ Phone: _____

Print Name: _____

SELF - CARE

Dressing: ☐ Maximum Assistance ☐ Moderate Assistance ☐ Minimal Assistance ☐ Supervision Only
☐ Independent ☐ U/E ☐ L/E

Bathing: ☐ Maximum Assistance ☐ Moderate Assistance ☐ Minimal Assistance
☐ Supervision Only ☐ Independent ☐ U/E ☐ L/E

Hand Dominance: ☐ Right ☐ Left

Recommended seating system if applicable: _____

_____

_____

Sitting Tolerance during the day (limiting factor identified): _____

_____

IADL'S Prior to Admission: Cooking I A D Grocery Shopping I A D Driving I A D Medication I A D
Cleaning I A D Banking I A D Laundry I A D

COGNITIVE STATUS	Not Tested	Intact	Impaired (specify)
Orientation	☐	☐	☐ _____
Attention	☐	☐	☐ _____
Memory (short term)	☐	☐	☐ _____
Memory (long term)	☐	☐	☐ _____
Judgment	☐	☐	☐ _____
Insight	☐	☐	☐ _____
Frustration tolerance	☐	☐	☐ _____

Comments: _____

_____

_____

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PART 3: To be completed by REGISTERED NURSE if the client is hospitalized at the time of application, otherwise by Physician.

Signature: _____ Phone:_____

Print Name:_____

CONTINENCE Bowel: ☐ Yes ☐ No Bladder: ☐ Yes ☐ No Indwelling Catheter ☐ Yes ☐ No

Condom Catheter: ☐ Yes ☐ No Intermittent Catheterization: ☐ Yes ☐ No

Toileting Plan Initiated? ☐ Yes ☐ No (specify)_____

(e.g., using urinal, bed pan, commode by bed, etc)

SPECIAL NEEDS:

Pressure Ulcers: ☐ Yes ☐ No Stage:_____ Size:_____ Location:_____

Wound Management: VAC:_____ Mattress:_____

Wound Dressings: ☐ Yes ☐ No If yes, specify:_____

Surgical Incision: ☐ Yes ☐ No If yes, specify:_____

Tracheotomy: ☐ Yes ☐ No If yes, specify:_____

Oxygen: ☐ Yes ☐ No If yes, specify:_____

Suction: ☐ Yes ☐ No If yes, specify:_____

I/V Lines or Picc: ☐ Yes ☐ No If yes, specify:_____

Pain: ☐ Yes ☐ No If yes, specify:_____

Capillary Blood Glucose Monitoring:

☐ Yes ☐ No If yes, specify:_____

Dialysis: ☐ Yes: ☐ Hemo ☐ Peritoneal If yes, specify schedule:_____

CDiff: ☐ Yes ☐ No

MRSA: ☐ No ☐ Yes Contact ☐ Yes Strict Isolation Date of last swabs:_____

VRE: ☐ No ☐ Yes

Is individual in isolation: ☐ Yes ☐ No if yes, why:_____

Sleep: Throughout the night ☐ Yes ☐ No Difficulty Sleeping ☐ Yes ☐ No

Sedation Required ☐ Yes ☐ No

Behavior Issues: ☐ No ☐ Yes If yes, specify:_____

☐ Physical Aggression ☐ Verbal Aggression ☐ Self-abuse ☐ Wandering ☐ Inappropriate sexual behavior

☐ Other/Specify:_____

_____

_____

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PART 4: To be completed by SPEECH LANGUAGE PATHOLOGIST if the client is hospitalized at the time of application,otherwise by Physician or Nurse.

Signature: _____ Phone:_____

Print Name:_____

COMMUNICATION

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 gesturing ☐ Completely impaired

Language spoken:_____

Language comprehension: ☐ Intact ☐ Follows basic instruction ☐ Impaired

Comments:_____

_____

PART 5: To be completed by DIETITIAN if the client is hospitalized at the time of application, otherwise by Physician or Nurse.

Signature: _____ Phone: _____

Print Name:_____

NUTRITION:

Current Diet:_____

NG:_____ G-Tube:_____ J-Tube:_____

TPN:_____ PPN:_____

Dysphagia Assessment: ☐ Yes ☐ No If yes, date (YYYY/MM/DD):_____

Concerns re: nutritional status:_____

_____

_____

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PART 6: To be completed by SOCIAL WORKER if the client is hospitalized at the time of application, otherwise by Physician or Nurse.

Signature: _____ Phone: _____

Print Name: _____

SOCIAL ASSESSMENT

Client Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Lives: ☐ Alone ☐ With Spouse ☐ Other _____

Home Environment: ☐ ____ Level Home ☐ Apt ☐ In-law Suite ☐ Other _____

☐ ____ Steps Outside ☐ ____Steps Inside

☐ Location Bedroom _____

☐ Location Bathroom _____

☐ Able to move to 1st floor if necessary: ☐ Yes ☐ No ☐ N/A

Substitute Decision-Maker: _____

Relationship to Client: ☐ Spouse/partner ☐ Parent ☐ Sibling

☐ Daughter ☐ Son ☐ Other _____

Employed at Time of Injury/Event? ☐ Yes ☐ No

Type and Duration of Employment: _____

_____

Financial Supports: _____

_____

Family/Community Support Network (who, how available, how often interactions): _____

_____

_____

_____

Additional Information (hobbies, interests, relevant facts): _____

_____

_____

Discharge Plan: _____

_____

_____

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CLIENT'S CONSENT FOR APPLICATION

I, _____ agree to attend Nova Scotia Rehabilitation Centre (NSRC) for assessment/rehabilitation, understand that assessment and/or rehabilitation entails a short-term stay, not permanent residence at Nova Scotia Rehabilitation Centre.

Client's Signature:_____ Date:_____

Witness:_____ Date:_____

If the client is unable to consent, the closest person responsible for him/her should sign:

Signature:_____ Date:_____

Name (please print):_____ Relationship:_____

Witness:_____ Date:_____

CLIENTS APPLYING FROM HOME:

HOME CAREGIVER'S CONSENT

As the family representative responsible for _____ 's care, I understand that, following the assessment and/or rehabilitation process, I will again assume responsibility for my family member at home.

Signature:_____ Date:_____

Name (please print):_____ Relationship:_____

Witness:_____ Date:_____