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	❑ Indep	❑ SBA/Cueing	❑ Assist
	Bathing	❑ Indep	❑ SBA/Cueing	❑ Assist
	Toileting	❑ Indep	❑ SBA/Cueing	❑ 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	❑	❑	❑	_____
Attention	❑	❑	❑	_____
Memory	❑	❑	❑	_____
Judgement	❑	❑	❑	_____
Insight	❑	❑	❑	_____
Initiation	❑	❑	❑	_____
Planning	❑	❑	❑	_____
Problem Solving	❑	❑	❑	_____
Visuospatial	❑	❑	❑	_____

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