Hamilton Niagara Haldimand Brant **LHIN** | **RLISS** de Hamilton Niagara Haldimand Brant

Complex Care & Rehabilitation Application Form

Contact the HNHB LHIN at **1-800-810-0000 Ext 1713**

** Required Field*

Patient Name* ________________ **HCN***__________ **VC***____ **DOB***________ **Gender***________
Address*______________________ **City***__________ **Province***_____ **Postal Code***________
Patient Phone* ______________ **Height*** ________ **Weight ***________ **Hospital Admission Date***__________
Primary Language* ☐ English ☐ French ☐ Other – specify ____________ **Patient Speaks and Understands English*** ☐ Yes ☐ No
Interpreter Needed* ☐ Yes ☐ No Specify ______________ **Family Physician***____________________

Emergency Contact Information

Primary Contact* __________________ **Relationship***__________ **Phone***______________
Power of Attorney Personal Care ____________________________ **Phone** ______________
Power of Attorney Financial Care ____________________________ **Phone** ______________
Substitute Decision Maker ____________________________ **Phone** ______________
Public Guardian & Trustee ____________________________ **Phone** ______________

Referral Source

Hospital Site* ______________ **Sending Unit*** ________ **Community Agency** ______________
Primary Contact for Bed Offer*______________________________________
Phone* ______________ **Fax*** ______________ **Cell Phone***______________

Application Stream and Choices

Complex Care/Rehab Stream*____________________ **CC/LIR Bed Type***______________
High Intensity Rehab Bed Type* ____________________ **Readiness Date*** ______________

☐ BCHS ☐ HDS ☐ HHS ☐ HHS–SPH ☐ HHS–WLMH ☐ HWMH ☐ JBH ☐ NGH ☐ NH-DMH ☐ NH-GNG ☐ NH–PCH ☐ NH–WHS ☐ SJHH

Isolation Status

Isolation* ☐ Yes ☐ No **ARO Status** ☐ MRSA ☐ VRE ☐ C-Diff ☐ Other –specify____________________

Discharge Plan (Destination and Care Plan)

☐ **Home** ☐ **Supervised or Assisted Living** ☐ **Retirement Home – specify** ____________________
☐ **Other – specify** ______________________________________
Previous Community Supports? If yes, specify ______________________________
Discharge Plan discussed with patient/family ☐ Yes ☐ No **Date** ____________________
Information provided to ______________ **Information provided by** ______________

Planned Discharge – Barriers & Challenges

Describe any known barriers or challenges to discharge (e.g. homelessness, family dynamics, home renovations, no support system.)

Patient Name ______________________________ **HCN** ____________________

Diagnosis / Medical History

Relevant Medical Diagnosis (reason for application) **Primary Diagnosis*** ____________________

Relevant Co-Morbidities

Upcoming Appointments / Pending Investigations / Scheduled Tests and/or Procedures ☐ **More information in ClinicalConnect**

Type	Physician / Surgeon	Scheduled Date	Notes

☐ **Smoking** ☐ **Alcohol** ☐ **Non-Script Drugs -specify**____________________

Allergies* (Medication, Environmental, Food) ____________________ ☐ **Document(s) Attached**

Advanced Directives ☐ Yes ☐ No If yes, specify ____________________ ☐ **Document(s) Attached**

Palliative Performance Scale (PPS) ______ **Spiritual Needs** ____________________

Mobility

Weight Bearing Status

Upper Extremity Left	**Date of Assessment**
Upper Extremity Right	**Date of Assessment**
Lower Extremity Left	**Date of Assessment**
Lower Extremity Right	**Date of Assessment**

Current Sitting Tolerance minimum 2-3 hrs./day ☐ Yes ☐ No ☐More than 2 Hours ☐ 1-2 Hours ☐ Less than 1 Hour Daily ☐ Has Not Been Up

If No, explain ____________________

Potential Therapy Tolerance (More than 1 hour per day up to 7 days/week) ☐ Yes ☐ No

If No, explain ____________________

Bed Mobility (Movement Restrictions/Precautions)____________________

Neuro Rehab only - ☐ Alpha FIM Motor __________ Cognitive __________ Total ________

Participation Notes

☐ Special Equipment - specify ____________________

☐ Specialty Bed/Mattress (e.g. Bariatric, air mattress) – specify ____________________

☐ One Person Transfer

☐ Two Person Transfer

☐ Mechanical Lift

Patient Name ____ **HCN** ____________________________

Functional Status & Goals

1 = Total Assistance, 2 = Maximal Assistance, 3 = Moderate Assistance, 4 = Minimal Assistance, 5 = Supervision, 6 = Modified Independence, 7 = Complete Independence

	Premorbid Status	Current Status	Required Status to Achieve discharge plan (SMART GOALS / Compensatory Strategies)	Demonstrates Recent Progress Y/N	Explain
Self Care					
Eating					
Grooming					
Bathing					
Dressing – Upper Body					
Dressing – Lower Body					
Toileting					
Sphincter Control					
Bladder Management					
Bowel Management					
Mobility/Transfer					
Bed– Chair – Wheelchair					
Toilet					
Tub –Shower					
Locomotion					
Walk-Wheelchair					
Stairs					
Communication					
Comprehension					
Expression					
Social Cognition					
Social Interaction					
Problem Solving					
Memory					

Cognition

Observed Behaviours (present or exhibited within the last 3 days)

☐ Verbally Responsive ☐ Physically Responsive ☐ Demonstrating Agitation ☐ Resisting Care ☐ Wandering ☐ Sun Downing

☐ Exit Seeking ☐ Bed Exiting ☐ Other ____

Restraints Required? ☐ Yes ☐ No **Restraint Type** ☐ Physical ☐ Chemical ☐ Environmental Specify ____________________

Behavioural Management Plan attached ☐ Yes ☐ No

Cognitive Assessment Score __________ **Assessment Tool Used** ______________________________ **Depression Score**___________

Patient Name ____ **HCN** _____________________________

Medical Management

☐ Pain Management Strategy ☐ Yes ☐ No Pain Pump Type _____________

Pain Frequency ____________________________________ Pain Intensity ________________________

☐ Tracheostomy Size _________ Type ________ ☐ Suction – Type ____________ ☐ IV Therapy - Access Line __________________

☐ Number of wounds & location ____ ☐ Wound Reports Attached

☐ Drain(s) Details __________________________________ ☐ Negative Pressure Wound Therapy - Details ________________________

Ostomy/Colostomy ☐ Old ☐ New ☐ Revised ☐ N/A ☐ Ostomy Report Attached Level of Care ____________ Catheter ☐ Yes ☐ No

☐ Feed Tube _________________ Diet Type __________________ Fluid Type _________________

☐ Halo ☐ Orthosis ☐ Pleuracentesis ☐ Paracentesis

☐ Bi PAP ☐ CPAP (Patient must bring own machine) ☐ Oxygen Required ☐ RT Required

☐ Chemotherapy Frequency _____________________ ☐ Radiation Frequency ___________________________

☐ Dialysis Schedule ____________________________ ☐ Peritoneal Dialysis Schedule _____________________

Other

Relevant Attachments (please provide the following if not available to the receiving organizations electronically)

☐ Recent patient history and relevant assessments/consult notes

☐ Last relevant lab results

☐ Progress notes summarizing current medical conditions (within last 72 hours)

☐ Medication list (BPMH, MAR, medication record, discharge medication record)

Completed by* Signature* Date*

Patient or Substitute Decision Maker Consent*

I understand the above information and agree to proceed with information sharing for the purposes of a complex care and/or rehabilitation application.

_______________________________ _______________________________ _______________

Printed Name of Patient or Substitute Decision Maker * Signature * Date * (dd/mm/yyyy)

Applications for Complex Care and Low Intensity Rehabilitation	Applications for High Intensity Rehabilitation Fax to Hospital Programs
Fax to HNHB LHIN at 1-905-639-6688	Joseph Brant Hospital: 905-681-4849
	St. Joseph's Healthcare Hamilton: 905-540-6503
	Hamilton Health Sciences: 905-521-2359
	Hotel Dieu Shaver: 905-685-0206
	Brant Community Healthcare System: 519-751-5542