Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Admission Application

Name: ______________________ **Date** (year/month/day) ______________

Diagnosis: ____

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Other comorbid conditions: Please describe.

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Hospital ALC Designation: ☐ CCC ☐ Active Rehab

Medically Stable, i.e. the patient must be medically complex / clinically stable.

- ☐ Known diagnosis
- ☐ No unresolved issues such as nausea, diarrhea, vomiting, dehydration or active haemorrhaging
- ☐ Infections, organisms identified and treatment plan in place
- ☐ Established diabetes management
- ☐ Established dialysis regime
- ☐ Established palliative care regime
- ☐ Psychiatry disorder stable
- ☐ Completion of acute care diagnosis tests (at the discretion of the HDS MRP)

VRE Positive ☐ Contact ☐

MRSA Positive ☐ Contact ☐

Isolation Precaution Required ☐ ______________________________

Identified Discharge Destination (D = desired as per patient/family E = expected as per therapist/team)

Home / independent living ______ Home / family ______ Retirement Home ______

Long Term Care facility ______ Application completed Yes ________ No ________

Other (please specify) ______ ______________________________

Special Treatment and Equipment Needs: Details:

- ☐ IV Central Line ______________________________
- ☐ Peripheral Line ______________________________
- ☐ PICC Length: ______________________________
- ☐ Other ______________________________

Tracheostomy (type and size)______________________________

Ostomy (type and size) ______________________________

Suctioning: frequency ______________________________

Oxygen: ______________________________

Respiratory Device: Type ______________ Rental/owned by ______________

☐ Gastrostomy: Insertion Date ______________________________

☐ Jejunostomy: Feed Regime ______________________________

Formula Type ______________________________

☐ Dialysis: Type ______________ Frequency ______________

☐ Other: (catheter, etc.) ______________________________

____

Safety Needs (adapted call bell, restraints, low bed, etc.)

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____

Wounds:

Location	Stage	Treatment	Frequency

Therapeutic Surface Needs: ____

____

Current Functional Status:

Tolerance for therapeutic intervention: (PT, OT, SLP, etc.)
☐ Less than 1 hour ☐ 1 – 2 hours ☐ 3 or more hours

Ambulation:
- ☐ Independent or Supervised
- ☐ Assistance
- ☐ Dependent (1-person)
- ☐ Dependent (2-person)
- ☐ Unable to ambulate at this time
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair ☐ Owned by patient

Bed Mobility:
- ☐ Independent or Supervised
- ☐ Assisted
- ☐ Dependent (1-person)
- ☐ Dependent (2-person or mechanical lift)

Toilet Use:
- ☐ Independent or Supervised
- ☐ Assisted
- ☐ Dependent (1-person)
- ☐ Dependent (2-person or mechanical lift)
- ☐ Incontinent ☐ Bowel ☐ Bladder

Transfer:
- ☐ Independent or Supervised
- ☐ Assistance
- ☐ Dependent (1-person)
- ☐ Dependent (2-person)
- ☐ Mechanical Lift

Eating:
- ☐ Enteral feed
- ☐ Independent or Supervised
- ☐ Assisted
- ☐ Dependent

Diet type: ____

Cognitive Deficit: ☐ No ☐ Yes

Describe: ______________________________

Behaviours: (check all that apply)

☐ Wandering	☐ Resistive	☐ Bed-Exiting
☐ Aggression	☐ Disruptive	☐ Exit-Seeking

Please describe:

____

____

Sleep Patterns: ______________________________

Language: ______________________________

Communication: ☐ Normal ☐ Difficult ☐ Aphasic

Communication device: ______________________________

Advance Directives: ☐ Yes ☐ No

Special Planning Issues (eg. family dynamics, discharge planning needs, appointments with other agencies, dialysis, treatment or transportation, etc.)

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* History and physical notes, consults and medication reports to be accessed through Meditech.

Name (please print)

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Signature: ____________________ **Date:** ____________________

**Please fax completed form to Admitting Department,
Hotel Dieu Shaver Health and Rehabilitation Centre, at 905-685-0206**