St. Joseph's Healthcare Hamilton

Complex Care Program Admissions: 905-540-6528 (F)
Medical Rehabilitation Program Admissions: 905-540-6503 (F)
Senior Mental Health Behavioural Program Admissions: 905-381-5657 (F)

Complex Care & Rehabilitation Application Form

** 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 _____ **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 Required? ☐ Yes ☐ No **ARO/Isolation Reason** ☐ MRSA ☐ VRE ☐ C-Diff ☐ Other – Specify_____

COVID-19 Status ☐ Positive ☐ Negative ☐ Resolved_____

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 Clinical Connect**

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

☐ One Person Transfer

☐ Special Equipment – specify_____ ☐ Two Person Transfer

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

Patient Name_____ **HCN**_____

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**_____

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

☐ Last relevant lab results ☐ Medication list (BPMH, MAR, medication record, discharge medication record)

Completed by* Signature* Date*

Patient or Substitute Decision Maker Consent*

The above information has been explained to me by_____and I have had the opportunity to ask questions about the program and discharge process.

I understand that:

1. The above information will be shared for the purposes of a complex care and/or rehabilitation application
2. These programs are transitional in nature
3. I will transition out of hospital when my complex care/rehabilitation care needs are met or can no longer be met in hospital and a suitable alternate plan has been developed.

_____ _____ _____

Printed Name of Patient or Substitute Decision Maker* Signature* Date*