CONFIRMATION OF MEDICAL STABILITY AND PROGRAM READINESS
INPATIENT REHABILITATIVE CARE AND OTHER COMPLEX CONTINUING CARE

PATIENT'S PERSONAL INFORMATION

Last Name | First Name | ☐ Male
Date of Birth Year/Month/Day | Health Insurance Number: | ☐ Female

REFERRAL SOURCE

Facility/ Community Agency: | Discharge Planner/SW:
Phone: | Pager: | Fax:

PROGRAM READINESS CHECKLIST (to be completed by Primary Contact Person)

- ☐ The patient has restorative potential, (i.e. there is reason to believe that the patient's/client's condition is likely to improve functionally and benefit from rehabilitative care)
- ☐ The patient/client has identified goals that are specific, measurable, realistic and timely; Goals for therapy must be SMART goals (specific, measurable, attainable, realistic and with time frame).
- ☐ The patient/client is able to participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of his/her specific functional goals, at the intensity of the level of rehabilitative care selected
    - has no behavioural or mental health issues, which cannot be mitigated through the use of strategies, resources and/or environmental modifications, and which limit the patient's ability to participate.
    - has sufficient cognitive ability and the physical tolerance to participate in and progress during rehabilitative care (although the patient's initial functional tolerance may fluctuate). Patient may require cueing and repetition, but demonstrates some functional improvement.
    - other comorbid illnesses will not interfere with the individual's ability to actively participate in the program on a daily basis (for example, ongoing treatment which will require frequent trips off site and may impact activity tolerance)
- ☐ Patient has special needs ☐No ☐Yes, if yes please specify:

_____

Current Isolation Status: □ Yes □ No Positive for: □ MRSA □ VRE □ C Diff □ Other _____

MEDICAL STABILITY CHECKLIST (to be completed by Most Responsible Physician or RN(EC))

- ☐ The patient is medically stable such that s/he can be safely managed with the resources that are available within the level of rehabilitative care being considered.
- ☐ a clear diagnosis for acute issues; co-morbidities have been established;
- ☐ there are no unaddressed acute medical issues (e.g. excessive shortness of breath, congestive heart failure, abnormal vital signs);
- ☐ all consults and diagnostic tests for the purposes of diagnosis or treatment of acute conditions have been completed and reported or pending test results are not anticipated to dramatically change the treatment plan.
- ☐ all abnormal lab values have been acknowledged and addressed as needed;
- ☐ medication needs have been determined;
- ☐ there is an established plan of care. However, some patients (particularly those in the Short and Long Term Complex Medical Management levels of rehabilitative care) may experience temporary fluctuations in their medical status, which may require changes to the plan of care.
- ☐ A follow-up plan is in place at the time of the referral and follow-up appointments have been made at the time of discharge from the acute hospital.

Comments:_____

Signature: _____(MD/RN (EC)) | Name:_____ | Date:_____

VERBAL CONFIRMATION (If MD/RN (EC) not available)

Confirmation of medical stability was provided verbally by _____ to _____on _____
(MD/RN (EC)) (Name of Primary Contact) (Date/time)

Signature (Primary Contact Person) _____

Fax application for:	**Fax Number:**
Rehabilitative Care (Rehab, Activation/Restoration, Complex Medical Management).....WWLHIN	(519) 742-0635
Neurobehavioural and Geriatric Assessment Units .....GRH Freeport	(519) 749-4326

Do NOT use this application for Palliative care referrals.