Bloorview Kids Rehab
150 Kilgour Road
Toronto, ON M4G 1R8
Fax: (416) 494-2736

Bloorview KIDS REHAB

REFERRAL FORM: REHABILITATION, COMPLEX CONTINUING CARE & RESPITE

To be completed in pen by a health care professional or family member. Please print legibly.

Name of Client:

Surname | Given | Initial | Preferred Name/Nickname

Primary Diagnosis: ______

Secondary Diagnosis: ______

Surgical Interventions: ______

Reason for Admission: ______

Requested Admission Dates: ______

FOR OFFICE USE ONLY:			
☐ Respite	☐ BIRT	☐ SODR	☐ Complex Continuing Care

PERSONAL		
DEMOGRAPHICS [ ] see attached	☐ Male ☐ Female Birthdate Y M D Age:	Religion/Culture/Traditions:
	Overnight Hospital Admissions within the last 6 months ? Yes ☐ No ☐ Immunizations Up to Date: Yes ☐ No ☐	Had Chicken Pox: Yes ☐ No ☐
LANGUAGES / INTERPRETER [ ] see attached	Languages spoken/understood by child 1. 2.	Languages spoken/understood by family: 1. 2.
	Interpreter required for child: Yes ☐ No ☐	Interpreter required for family: Yes ☐ No ☐
	Interpreter's Name & Phone Number:	
PARENTS INFORMATION [ ] see attached	Mother's Name ______ Address ______ ______ Home(H) (W)	Father's Name ______ ______ ______ H) (W)
LEGAL GUARDIAN & NOTIFY IN EMERGENCY [ ] see attached	Legal Guardian: Guardian'sName: ______ Address: ______ ______ Home(H) ______ (W) ______	In Case of an Emergency: Contact's Name: ______ Relationship: ______ Address: ______ ______ Home(H) (W)
PRIMARY PHYSICIAN	Name: Phone #:	
	Address:	
HEALTH CARD & INSURANCE INFORMATION	Health card number:	Other Health Insurance Information: (Name, Group Number, Policy Number)
	If Motor Vehicle Accident, please complete the following information: Insurance Company Name: ______ Telephone: ______ Case Manager's Name/Company : ______ Telephone: ______ Lawyer's Name/Firm: ______ Telephone: ______	

HEALTH HISTORY

BRIEF MEDICAL HISTORY:

[ ] see attached

MEDICATIONS (oral, feeding tube, topical, inhalation, etc.) State medication, times and methods of administration, dose and helpful hints.
Remind family to bring in meds in original containers. [ ] see attached

ALLERGIES (drug, food [i.e., peanuts], latex, etc.)

ROUTINES / PROCEDURES /TREATMENTS (e.g., dressings, etc.)

RECENT LAB REPORTS (Blood, X-ray, i.e. MRI, CT Scan e.g) [ ] ATTACH COPIES

SPECIAL PSYCHOSOCIAL ISSUES

WHAT IS THE FAMILY'S UNDERSTANDING OF THE DIAGNOSIS/PROGNOSIS?

WHAT IS THE DISCHARGE PLAN?

OTHER?

01. MOBILITY

___ Immobile ___ Bedrest

___ Walks with assistance ___ Walks Independently

AIDS/SEATING

___ Manual W/C ___ Electric W/C

___ Stroller ___ Insert type ____________________

___ Walker

___ Other ____________________

____

BRACES/PROSTHESIS

Type ____________________

____

TRANSFERS

___ Independent ___ Requires supervision

___ Requires assistance ___ One person

___ Two person ___ More than two or lifting aid

02. SAFETY

___ Type of bed ____________________

___ Bed rails

___ Rail padding ____________________

___ Physical restraints

___ Climbs out of bed ___ Dome over bed

___ Helmet _____ Anti tip bars and belt on Wheelchair

___ Other

Specify: ____________________

____

____

03. NUTRITION

___ Breastfed ___ Bottlefed

___ Difficulty chewing ___ Difficulty swallowing

Gag reflex present ___ Yes ___ No

___ Consistency of food

___ Pureed ___ Ground ___ Regular

___ Gastrostomy (G) Tube ___G/J tube

___ Nasogastric (NG) tube

Tube size/type ____________________

___ Total Parenteral Nutrition

Type & amount of feeding/formula:

____

____

Likes/dislikes: ____________________

____

Other (e.g. cultural/religious diet implications): ____________

____

____

COMMENTS: ____________________

____

04. ELIMINATION

BOWEL

___ Full control

___ Bowel routine (to maintain control)

___ Occasionally incontinent

___ Incontinent ___ Toilet training

___ Commode

Type/size of diaper ____________________

Comments: ____________________

BLADDER

___ Full control

___ Bladder routine (to maintain control)

___ Occasionally incontinent

___ Incontinent

___ Catheter routine (times) ____________________

Type/size ____________________

___ Drainage condom

Comments: ____________________

05. SENSORY

VISION

___ Adequate ___ Impaired ___ Blind

Glasses Yes ☐ No ☐

___ Prosthesis

HEARING - (with aid, if worn)

___ Adequate ___ Impaired ___Deaf

Device type ____________________

06. LEVEL OF CONSCIOUSNESS

___ Alert ___ Lethargic

___ Semi-comatose ___ Comatose

GCS: ____________________

07. LEVEL OF UNDERSTANDING

___ Normal

___ Delayed: ___ Mild ___ Moderate ___ Severe

Comments: ____________________

____

RANCHOS CURRENT LEVEL: ____________________

08. ACTIVITIES OF DAILY LIVING -

ABILITY TO DRESS

___ Independent ____ Requires supervision

___ Requires assistance/aids ____ Dependent

Comments: ____________________

____

HYGIENE

___ Independent ___ Dependent

___ Requires supervision ___Requires assistance/aids

Comments: ____________________

____

SLEEP

___ Sleeps most of the night ___ Awakens frequently

___ Night care routines Describe: ____________________

____

Daytime naps ____ Yes ____ No

Comments: ____________________________________

____

09. BEHAVIOUR/COPING PATTERNS

___ Co-operative ____ Withdrawn

___ Agitated: ____ Nighttime ____ Daytime

___ Aggressive: ____ Verbally ____ Physically

___ Wanderer

___ Triggers: ___ Noise ____ Light ____ Frustration

Comments: ____________________________________

____

CONCENTRATION/ATTENTION SPAN

___ Normal ___ Impaired

___ Requires 1:1 supervision

___ Close observation ___ Normal observation

Reason/Comments: _______________________________

____

10. COMMUNICATION

SPEECH

___ Able to state needs ___ Communicates with difficulty

___ Unable to communicate

___ Communication devices utilized

Describe: ____________________________________

____

11. SEIZURE ACTIVITY

Yes _____ No _______

Describe frequency, type, triggers

____

____

____

12. SKIN CONDITION

___ Normal ___ Wound/Incision(s)

___ Burn ___ Stoma Care ___ Other

Describe: ____________________________________

____

____

13. SPECIAL NEEDS

___ Suction ____ Oxygen

___ Ventilator: ___ Nighttime Only ___ 24 Hours

___ Tracheostomy _____ Peripheral IV

___ Central Venous Line _____ Internal _____ External

___ Dialysis ____ Monitor

Describe any other Supplies/Equipment required: __________

____

____

____

14. SCHOOL

Home School Name: _____________________________

School address: ________________________________

Telephone Number: ______________________________

Teachers Name: ________________________________

Grade **:** ____________________________________

15. COMMUNITY /HOSPITAL RESOURCES INVOLVED

Please Specify:

____

____

____

____

____

____

____

____

16. **RELIGIOUS/CULTURAL TRADITIONS**

Does your child have any cultural and/or religious customs that they will observe during their stay? ________________________

____

____

Signature of Person Completing Form: ______________________________ Date: ____________

Referring Source: ____

Signature of Nurse Reviewing Form on Admission: _______________________ Date: ____________

_______________________ Date: ____________

_______________________ Date: : ____________

_______________________ Date: ____________

If assistance is required in completing this form, please contact the Intake/Discharge Co-ordinator at (416) 753-6030.