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| **Complex, Palliative & Rehabilitation Application Form** *\* Required Field***Patient Name\* HCN\* VC\* DOB\*** dd/mm/yyyy **\_ Gender \*\_\_\_\_\_\_\_\_\_\_\_** |
| **Address\* City\* Province\* Postal Code\*** **Patient Phone\* Height\* Weight\* Hospital Admission Date \***dd/mm/yyyy |
| **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** **Sending Unit\*** **Primary Contact for Bed Offer\*** **Phone\* Fax\* Cell Phone\***  |
| **Application Stream and Choices** ☐ **High Intensity Rehab** ☐ **Low Intensity Rehab** ☐ **Complex Care ☐ Palliative Care Readiness Date\*** dd/mm/yyyy |
|  **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 dd/mm/yyyy Information provided to Information provided by**

**48 Hour conversation completed?** ☐ Yes ☐ No **Planned Discharge – Barriers & Challenges****Describe discharge plan and any known barriers or challenges to discharge** (e.g. homelessness, family dynamics, home renovations, no support system.) |

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# Patient Name HCN

**Diagnosis / Medical History**

 **Palliative Performance Scale (PPS)**  *\* Required, If Applying for Palliative Care Unit\**

(Requirement for JBH Palliative Care Unit: less than or equal to 30% PPS)

Link: [Palliative Performance Scale PPSv2 (myjosephbrant.ca)](https://myjosephbrant.ca/en/department-information/resources/RehabComplexCare/Applications/palliative_performance_scale_PPSv2.pdf)

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

Relevant Co-Morbidities

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

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| --- | --- | --- | --- |
| **Type** | **Physician / Surgeon** | **Scheduled Date** | **Notes** |
|  |  | dd/mm/yyyy |  |
|  |  | dd/mm/yyyy |  |
|  |  | dd/mm/yyyy |  |
|  |  | dd/mm/yyyy |  |

* **Smoking** ☐ **Alcohol** ☐ **Non-Script Drugs -specify Allergies\* (Medication, Environmental, Food)**
* **Advanced Directives** ☐ Yes ☐ No If yes, specify

Spiritual Needs

 **Mobility**

Weight Bearing Status

|  |  |
| --- | --- |
| Upper Extremity Left | **Date of Assessment** dd/mm/yyyy |
| Upper Extremity Right | **Date of Assessment** dd/mm/yyyy |
| Lower Extremity Left | **Date of Assessment** dd/mm/yyyy |
| Lower Extremity Right | **Date of Assessment** dd/mm/yyyy |

**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** (Daily for up to 6 days/week) ☐ Yes ☐ No

If No, explain

**Bed Mobility** (Movement Restrictions/Precautions)

**Stroke referrals only -** ☐ Alpha FIM Motor

Participation Notes

Cognitive

Total

* 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**

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|  | **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** |
| BladderManagement |  |  |  |  |  |
| Bowel Management |  |  |  |  |  |
| **Mobility/Transfer** |
| Bed– Chair – Wheelchair |  |  |  |  |  |
| Toilet |  |  |  |  |  |
| Tub –Shower |  |  |  |  |  |
| **Locomotion** |
| Walk-Wheelchair |  |  |  |  |  |
| Stairs |  |  |  |  |  |
| **Communication** |
| Comprehension |  |  |  |  |  |
| Expression |  |  |  |  |  |
| **Social Cognition** |
| Social Interaction |  |  |  |  |  |
| Problem Solving |  |  |  |  |  |
| Memory |  |  |  |  |  |

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|  **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**

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| **Medical Management** * Pain Management Strategy ☐ Yes ☐ No Pain Pump Type

Pain Frequency Pain Intensity * Tracheostomy Size Type ☐ Suction – Type
* Number of wounds & location
* Drain(s) Details ☐ Negative Pressure Wound Therapy - Details

Ostomy/Colostomy ☐ Old ☐ New ☐ Revised ☐ N/A Catheter ☐ Yes ☐ No* PEG Tube PEG ☐ NG Diet Type Fluid Type
* Halo ☐ Aspen Collar ☐ Jewitt Brace
* 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 consult notes ☐ Progress notes summarizing current medical conditions (within last 72 hours)

 ☐ 48 hour conversation ☐ OT/PT initial assessment and updates  |
| Completed by\* Signature\* Date\* dd/mm/yyyy |
| **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 \* (dd/mm/yyyy) |