ST JOSEPH's HEALTH CARE LONDON

Parkwood Institute

Main Building – Inpatient Referral Form

Parkwood Institute is a smoke-free facility. This means there will be no smoking indoors or outdoors on the Parkwood Institute property, including in parking lots. Patients who wish to smoke must do so off the property.

PIN # ____
PATIENT NAME ________________________________
DOB (yyyy/mm/dd) ____________________________
Health Card # _________________________________
Family Physician _______________________________

REFERRAL DATE (yyyy/mm/dd)__________________
Referring Physician ___________________________
Referral Contact Person _______________________
Referral Contact Phone # ______________________
Current Location of Patient ____________________

PROGRAM REQUESTED (select one)

Complex Continuing Care
- ☐ Short Term Complex Medical
- ☐ Long Term Complex Medical
- ☐ Activation/Restoration

Rehab
- ☐ Acquired Brain Injury
- ☐ Spinal Cord Injury
- ☐ Stroke/Neuro
- ☐ MSK Rehab
- ☐ Geriatric Rehab
- ☐ Geriatric Day Hospital

HEALTH CARE DECISION MAKING

Has the patient/SDM agreed to this referral? Yes ☐ SDM Name: Phone:

ELIGIBILITY CRITERIA

- **Restorative potential:** ☐ Yes ☐ No
- **Medically/surgically stable:** ☐ Yes ☐ No
- **Identified goals and documented discharge plan:** ☐ Yes ☐ No
- **Able, willing and motivated to participate:** ☐ Yes ☐ No
- **Care needs cannot otherwise be met in the community:** ☐ Yes ☐ No

CLINICAL PROFILE

Primary Medical Diagnosis:

Date and Description of Event (example: stroke, trauma, fall):

Etiology:

Surgical Interventions/Procedures (current admission)**:**

Co-morbidities:

Complications (current admission)**:**

Outstanding/Pending medical investigations, procedures and appointments:

Infection Control precautions: Yes ☐ **No** ☐ If positive: **MRSA** ☐ **C Diff.** ☐

PATIENT SPECIFIC GOALS:

Patient Name/PIN: ________________________________

Please complete sections relevant to the patient and tick boxes that apply:

FUNCTION

I=Independent **S**=Supervision **minA**=Minimal Assist **modA**=Moderate Assist **maxA**=Max Assist **D**=Dependent

Bathing	Toileting
Dressing	Transfers
Feeding	Ambulation Distance

Restrictions: Collar □ Splints □ Braces □ Weight bearing restrictions ___________________________________

Equipment: Wheelchair □ Tilt □ Bariatric □ Standard □ AFO □

Bariatric Patient: Yes □ Alpha FIM Score (required for Stroke patients only): _________________________

COGNITION

I=Intact **D**=Diminished

Orientation (person, place, time)	Carry-over/New Learning
Ability to follow instructions	Insight/Judgment

If available: MOCA _____ MMSE _____ ☐ Communication barriers/needs ___________________________________

Please check if any of the following are present:

☐ Delirium ☐ Resistant Behaviours ☐ Verbal Aggression ☐ Physical Aggression ☐ Physical Restraints

Behaviour Management Strategies (attach plan if applicable): ______________ ☐ Wandering behaviours/exit seeking

CARE NEEDS

Diet: If not in Cerner: Type: ________________________________ Diet Texture: ________________________________

Tube Feed: If not in Cerner: Type: ____________________ Rate: ________________

Swallowing: ☐ Intact ☐ Impaired MBS completed: Yes ☐ (attach if not in Cerner)

Ostomy: Yes □ New □ Product types and #'s:

Wound(s): Yes □ Type and Location: ____

Treatment (if complex attach plan): ____

Drains/Tubes: Yes □ Type and Protocol:

IV: Yes □ Peripheral □ Central Line Type: Location:

Pain: Yes □ Acute □ Chronic □ Location:

Dialysis: Yes □ Type: Schedule:

Oncology Treatment: Chemotherapy □ Radiation □ Other □

Tracheostomy: Yes □ Date of insertion (YYYY/MM/DD): ____

Tube type and size : Frequency of suctioning per 24/hr.:

Oxygen: Yes □ Flow Rate:____________________ Delivery method:__________________

Humidified air: Yes □ Flow Rate:____________________ Delivery method:__________________ Prior Home Oxygen: □ Yes

Bipap: Yes □ New □ Established (patient is to bring own equipment to Parkwood Institute) □

Cpap: Yes □ New □ Established (patient is to bring own equipment to Parkwood Institute) □

Complex Continuing Care Co-Payment (for Long Stay Complex Medical Referrals Only):
The amount charged is set by the Ontario government and adjusted annually and is considered their contribution toward accommodation and meals.

Has the patient and/or their SDM/POA been informed of co-payment?: Yes □ No □

Please fax to 519-685-4804 along with documents not available in Cerner.
Please include Physicians' admission history, consults and most recent Nursing/Allied Health/Physician progress notes. If applicable, also include Behavioural Plan and Wound Care Plan.

E-mail: Parkwoodaccess@sjhc.london.on.ca ▪ Fax: 519-685-4804 ▪ Phone: 519-685-4809

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