Holland Bloorview
Kids Rehabilitation Hospital

Handover Documentation
FOR INPATIENT and DAYPATIENT

Reset Form | Print Form | Save Form

This client will be transitioning to Holland Bloorview (HBKR). To ensure a safe and smooth transition, we require the following form be filled out in full and faxed to **(416) 424-3883** 48 HOURS (2 business days) prior to date of transfer.

Up to Date as of:_____ Date of transfer to HBKR:_____
Client Information:_____
Surname Given Preferred/Nickname Date of Birth

◯ Brain Injury Rehab Team ◯ Specialized Orthopaedic Developmental Rehab ◯ Complex Continuing Care

Please Attach The Following (Where Applicable):
☐ Admission Note ☐ Intra-hospital Transfer Note ☐ Medication Profile/List ☐ Seating Assessment ☐ Complex Care Plan
Most Recent: ◯ Video Fluoroscopy ◯ Neuro Imaging ◯ Ortho Imaging ◯ Relevant Labs ◯ Teaching Checklist(s)

Medical History:
Primary Diagnosis:_____
Secondary Diagnosis/ese (include ASD):_____
Measurement: _____ Height/length (cm) _____ Weight (kg) _____ Head Circumference (cm)
Resuscitation: ◯ **Full Resuscitation** ◯ **Do Not Resuscitate** ◯ **Other:**_____
PACT Involvement: ◯ No ◯ Yes Advanced Directive ◯ No ◯ Yes, please explain:_____
Allergies:_____
Immunizations up to date: ◯ Yes ◯ No, please explain:_____
Had Chickenpox: ◯ Yes ◯ No ◯ Vaccination Had Measels: ◯ Yes ◯ No ◯ Vaccination
Flu Shot: ◯ Yes ◯ No
Level of Consciousness: ◯ Alert ◯ Lethargic ◯ Comatose
Rancho Scale Level ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ASIA Scale Score: _____
Seizure Activity: ◯ No ◯ Yes, please describe: (semiology, frequency, length, management): _____
Active Day Treatments (e.g. chemotherapy, radiation, IVIG): ◯ No ◯ Yes, please describe: _____

Infection Control
Isolation: ◯ No ◯ Yes, if yes: Isolation Precautions: ☐ MRSA ☐ VRE ☐ C. Diff ☐ Other, please explain:_____

Surgical History:
Post-Operative Admission: ◯ No ◯ Yes: Date, Type/Indication:
Other Relevant Surgical Interventions: _____

Cardiorespiratory Medical Devices:
Oxygen Supplementation: ◯ No ◯ Yes, FiO2 (%):_____ Mode of Delivery:_____
Suction: ◯ No ◯ Yes, Type:_____ Frequency:_____ Tolerance:_____
Tracheostomy: ◯ No ◯ Yes, date of insertion:_____
Date of last trach change:_____
Trach type:_____ Size:_____ Accessories (e.g. CAP/Speaking Valve):_____

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Ventilation:
◯No ◯ Yes, Date of Initiation:_____Model:_____Schedule/Tolerance:_____
Vent Settings:_____
Noninvasive Ventilation: ◯No ◯ Yes, ◯ BiPAP ◯ CPAP Other:_____
Mode: ☐Nasal Mask ☐Face Mask ☐Nasal Pillow ☐Mouthpiece ☐Chin Strap
Vent Settings:_____
Cardiac Devices: ◯No ◯Yes ☐Cardiac Pacemaker ☐Assisted Implanted ☐Cardiac Defib (AICD)
IV Access ◯No ◯ Yes, ☐CVC ☐PICC line/Port
Date of Insertion:_____Size:_____Length:_____
Other Medical Technologies: ◯No ◯Yes, ☐VP Shunt ☐Vagal Nerve Stimulator ☐Dialysis
Other: Comments/Others: _____

Nutrition:
Oral Feeding: ☐No-NPO
Growth Chart Attached: ☐
Safe to Feed PO: ◯ No ◯ Yes **Video Fluoroscopy:** ◯No ◯Yes ◯NA **Breast Fed:** ◯No ◯Yes ◯NA
Bottle Fed: ◯NA ◯ No ◯ Yes, ◯EBM or ◯ Formula:_____
Regular DAT: ◯ No ◯Yes, ◯NPO ◯Taste Stim:_____ ◯PO + Topups (ent. tube):_____
Diet Texture: ◯ Regular ◯Soft ◯Minced ◯Puree
Liquid Consistency: ☐Thin Liquid ☐Nectar ☐Honey ☐Pudding ☐No liquids
Alternative Feed Methods: ◯No ◯Yes, ☐G-tube ☐G/J-tube ☐NG-tube ☐TPN ☐Gravity OR ☐Pump
Other: (e.g. OG, GD, NJ, etc.):_____
Date of Insertion:_____Date Last Changed:_____
Tube Size:_____Type:_____Length/ measurement:_____
Feed Type:_____Volume of Feed:_____Rate of Feed:_____Schedule:_____
Feeding schedule and type (EBM, formula and name concentration, rate, flushes):_____
_____
Daily Requirements: TFI:_____Protein:_____Energy:_____
Comments:_____
Total Parenteral Nutrition (TPN) ◯Yes ◯No

Activities of Daily Living:
Sleep: Special Mattress Required ◯No ◯Yes, Type:_____
Comments:_____
Self-Care (e.g. bathing, dressing, feeding): ◯Independent ◯Needs Supervision ◯Needs Assistance
◯Dependent ☐Equipment Required:_____
Comments:_____
Skin Integrity:
☐Wounds ☐Incisions ☐Stoma, Please Describe:_____Specialized Dressing/care:_____
Wound care routine (e.g. shower/ bathing restrictions):_____

Bowel: ☐Continent ☐Incontinent ☐Bowel Routine/ Training ☐Commode Required
Comments:_____
_____

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Bladder: ☐Continent ☐Incontinent ☐Bladder Routine/ Training ☐Catheter, type/size/schedule:_____

_____

Functional Abilities:
Vision Impairment: ◯No ◯Yes, ☐Wears Glasses Hearing Impairment: ◯No ◯Yes, ☐Hearing Aid
Describe:_____

Mobility: ◯Ambulates independently ◯Non-ambulatory/bedrest only ◯Ambulates with Supervision
◯Walks with Aid, Describe:_____ ◯Sits Independently OR
◯With Supervision/Assistance
Comments:_____
Weight Bearing Restrictions: ◯No ◯Yes, ☐RIGHT Upper/Lower Extremity ☐LEFT Upper/ Lower Extremity

☐Non WB ☐Touch WB ☐Partial WB ☐WB as tolerated, Duration/comments:_____

_____

Activity Restrictions: ◯No ◯Yes,
Active ROM ◯Yes ◯No, Precautions:_____
Passive ROM ◯Yes ◯No, Precautions:_____
Strengthening/Resistance Training Permitted ◯Yes ◯No, Precautions:_____
☐Orthoses ☐Bracing ☐Stockings ☐Garments ☐Splints ☐Casts ☐**Helmets:**_____
For: ☐Head ☐Neck ☐Trunk ☐Upper Extremity: ☐L or ☐R ☐Lower Extremity: ☐L or ☐R
Wear at: ☐All Times ☐When Upright ☐Off in Bed ☐ Weight Bearing/ Mobilizing ☐Transportation Only
Describe Type:_____

Seating Aids: ◯No ◯Yes, ☐ Assessment Completed, Date of Assessment:_____
Aid Type:_____Dimensions (LxW):_____Client has Own Chair For Transition ◯No ◯Yes

Transfers: ☐Independent ☐Requires Supervision ☐ Requires Assistance of_____people ☐ Mechanical Lift
Comments:_____

Communication:
Expressive Speech and Language: ☐Functional ☐Impaired: ◯ Mild ◯Moderate ◯ Severe
☐Speech Errors ☐Alternative and Augmentative Communication Utilized
Voice impairment ◯No ◯Yes
Comprehension: ◯Functional ◯Impaired: ◯Mild ◯Moderate ◯ Severe

Comments: (e.g. reliable yes/no, key words, types of cueing)_____

_____

Education:
Family Education Required: ◯No ◯Yes, # of Family Caregivers: Relationship(s):_____
Type: ☐CPR ☐Trach ☐Trach-Vent ☐ NG or ☐ G-tube ☐ Catheterization ☐ Monitoring ☐Teaching in Progress,
Comments: (Status/ Learning Style)_____

Psychosocial:
Supports Required: ◯Routine OR ◯ Exceptional, Describe:_____
Active Services: ☐Social Work ☐ Instrumental AND/OR ☐ Supportive Counselling, Contact:_____

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☐Psychology ☐Psychiatry, Contact(s):_____

SCAN Involvement: ◯No ◯Yes, **CAS Involvement:** ◯No ◯Yes, Contact(s):_____

Custody/ Child Access:_____

Safety/ Supervision:

Risk Factors: ◯No ◯Yes, Describe:_____

1:1 Supervision Required: ◯No ◯Yes, Describe:_____

Funding:

Funding Support Required: ◯No ◯Yes, Describe:_____

Funding Application(s) In Progress: ◯No ◯Yes, Funding Profile Attached ☐

Community Services and Contacts:

MRP (Name/Phone No.):_____ **Community Clinic(s) (Name/Phone No.):**_____

Community School (Name/Phone No.):_____

Community Referral(s) made (e.g.) CCAC, OACRS, etc.):_____

IF MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Insurance Company Name:_____ Telephone:_____
Case Manager's Name/ Company:_____ Telephone:_____
Lawyer's Name/ Firm:_____ Telephone:_____