

MEDICAL REFERRAL FORM

Brain Injury Rehab Team

- Inpatient
 Day patient

**Specialized Orthopaedic
Developmental Rehab**

- Inpatient
 Day Patient

Complex Continuing Care

- Inpatient
 Day Patient

Referring Agency:

SickKids McMaster Children's London Children's CHEO

Other: _____

Key Team Contact: _____

Team Contact/Key Worker Contact#: _____

Referring Provider Contact#: _____ OHIP Billing Number: _____

MRP: _____ Contact#: _____

Information

Client Name: _____

Child's Primary Address: _____

City: _____ Postal Code: _____

Date of Birth: _____ Female Male

OHIP: No Yes, OHIP#: _____ Version Code: _____

If No, Please Explain: _____

Caregiver Name: _____ Relationship to Child: _____

Caregiver Contact#: _____

Interpreter Required: _____ No Yes If yes, for whom: _____

Language Spoken: _____

Name of Legal Guardian(s): _____

Relationship to Child: _____

Child Protection Agency: No Yes If yes, specify: _____

Information

Primary Diagnosis: _____

Secondary Diagnosis(es): _____

Isolation d/t Infection Control: No Yes If yes, isolation type & organism: _____

Current Medical History: Please attach a brief medical history or recent medical summary

Current List of all Medications: Please attach a complete medication list **or** complete the

Client Medication Profile (page 4)

Allergies No Yes If yes, please describe: _____

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Reason(s) for Referral (please indicate all that apply)

- Rehabilitation/Habilitation Goal(s): _____

- Teaching and Training Transition to Community

Post Acquired Brain Injury, Post Trauma, & Post Operative Information

- Trauma: _____ No Yes
If yes, date & mechanism of injury: _____

- Surgical Intervention: No Yes If yes, date & type of surgery: _____

- CPM (Continuous Passive Motion Machine): Yes No
- Seating Assessment Initiated: Yes No N/A
- Activity Restrictions: No Yes If yes, please describe: _____

- Rancho Level (Circle): 1 2 3 4 5 6 7 8 N/A

Disposition

- Medically Ready for Transition: Yes No, If no, estimated date of medical readiness: _____
- Safe for Discharge Home While Waiting for Admission to Holland Bloorview: Yes No
- Discharge Destination or Disposition from HBKR Identified: No Yes
- If yes, please specify: _____

- If residence other than child's primary, please provide caregiver address: _____

Seizure Activity

- No Yes, if yes, Pre-existing New onset
- Describe Seizures: _____

- Describe Seizure Management: _____

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Nutrition/Diet

Oral Feeding: No – NPO

- Yes – Expressed Breast Milk (EBM)/ formula
 Yes - Regular Diet Yes - Special Diet

Please describe type of diet and feeding schedule:

Enteral and Parenteral Nutrition Support:

- NG-tube OG-tube G-tube G/J tube
 Other, Please Describe: _____

Date of insertion: _____

Delivery: Pump Gravity

Feeding schedule and type (EBM, formula and name concentration, rate, flushes): _____

Total Parenteral Nutrition (TPN) Yes No

Please specify TPN type/formulation, or include in medication summary: _____

Anticipated Interventions Required

	Type	Frequency
<input type="checkbox"/> Imaging:		
<input type="checkbox"/> Blood Work:		
<input type="checkbox"/> Other:		

Access for Blood Work:

- Phlebotomy Central Line

Skin Condition:

- Normal Wound/Incision Burn
 Stoma Care Specialized Dressings
 Specialized Surface

Type: _____

- Other, Please Describe: _____

Other Needs:

Specialized Rehabilitation Equipment: Yes No

Complementary Therapies: Yes No

Please describe: _____

Medical Assistive Technology Anticipated at Time of Admission

- Oxygen Suction Tracheostomy: Type: _____ Size: _____ Date of Insertion: _____
 Invasive via tracheostomy (IPPV) Non-invasive (NIPPV e.g. BIPAP) CPAP Nocturnal only 24hrs
 Airvo In/exsufflator
 CVC/PICC line/Port Date of Insertion: _____ Size: _____ Length: _____
 VP Shunt Vagal Nerve Stimulator Dialysis Insulin Pump
 Other: _____

School Yes No School Name: _____ Grade: _____

Psychosocial/Behaviour Issues

Safety Risks (e.g. falls/wandering/aggression/ substance misuse) Yes No If Yes, details: _____

Safety Strategies (e.g. behavioural plan): _____

1:1 Supervision: No Yes If yes, type: PSW CYW Observers/Sitters Security

