nova scotia health authority

Division of Physical Medicine and Rehabilitation
Application for Admission to the
Nova Scotia Rehabilitation & Arthritis Centre

Date: _____ Completed form to be sent to Rehab Assessor at Fax # 902-473-4460
(YYYY/MM/DD)

MEDICAL ASSESSMENT: To be completed by a PHYSICIAN

Current Diagnosis: _____

_____

_____

_____

Date of Onset: _____ Date of Admission: _____

Past Medical History: _____

_____

_____

_____

Surgical Interventions and Dates: _____

_____

Current Findings/Status (Include physical assessment, lab/x-ray results, etc): _____

_____

_____

_____

Height: _____ Weight: _____

Is Individual on antibiotics: ❑ No ❑ Yes If yes, why: _____

Allergies: _____

Please sign below to indicate that you will accept the client back to your care if transfer to the referring facility is necessary upon discharge:

Signature: _____

MD Name: _____
(Please Print)

Phone contact # _____

CLIENT'S CONSENT FOR APPLICATION

***** Client consent must be signed prior to sending application.**

I, _____ agree to review of this application by the Nova Scotia Rehabilitation Centre (NSRC) team for possible admission.

If accepted for admission

I agree to fully participate with the rehab team and I understand it is for a short-term admission, not permanent residence at Nova Scotia Rehabilitation Centre.

Client's Signature: _____ Date: _____

Witness: _____ Date: _____

If the client is unable to consent, the closest person responsible for him/her should sign:

Signature: _____ Date: _____

Name (please print):_____ Relationship: _____

Witness: _____ Date: _____

ANTICIPATED REHABILITATION GOALS - <u>As identified by the patient and team:</u>

_____

_____

_____

_____

_____

_____

_____

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Part 1: To be completed by PHYSIOTHERAPIST or other appropriate team member.

Signature:_____ Phone: _____

Print Name: _____

FUNCTIONAL ASSESSMENT ***** For all Stroke applications - Patient's Barthel Score -** _____

***** For all Amputee applications - Patient's Amp NoPro Score -** _____

Activity tolerance for therapies (OT and PT): _____

Current Bed Mobility: Rolling ❑ Indep ❑ SBA/Cueing ❑ Min Mod Max Assist x _____ ❑ Dependent

Lie to sit ❑ Indep ❑ SBA/Cueing ❑ Min Mod Max Assist x _____ ❑ Dependent

Transfers: Prior to adm ❑ Indep ❑ SBA/Cueing ❑ Min Mod Max Assist x _____ ❑ Mechanical lift

Current ❑ Indep ❑ SBA/Cueing ❑ Min Mod Max Assist x _____ ❑ Mechanical lift

Comments: _____

Ambulation: Prior to admission ❑ Non – ambulatory ❑ 2 person ❑ 1 person ❑ SBA ❑ Indep Aid: _____

Current ❑ Non – ambulatory ❑ 2 person ❑ 1 person ❑ SBA ❑ Indep Aid: _____

Comments: _____

Balance: Berg Score _____ **Falls:** ❑No ❑ Yes, if yes Frequency _____

Limbs: **Strength** ❑ Normal ❑ U/E Impairment Right / Left ❑ L/E Impairment Right / Left

ROM ❑ Normal ❑ U/E Impairment Right / Left ❑ L/E Impairment Right / Left

Coordination ❑ Normal ❑ U/E Impairment Right / Left ❑ L/E Impairment Right / Left

Spasticity ❑ Normal ❑ U/E Impairment Right / Left ❑ L/E Impairment Right / Left

Comments: _____

_____

_____

Weight Bearing Status/Activity Restrictions: _____

_____

Present Treatment Program: _____

_____

_____

Part 2: To be completed by OCCUPATIONAL THERAPIST or other appropriate team member.

Signature: _____ Phone: _____

Print name: _____

Home Environment: ❑ Apt ❑ _____ Level Home ❑ Other _____

____ Steps outside ____ Steps inside ____ Ramp Location of Bedroom: _____ Location of Bathroom: _____

Able to move to 1st floor if necessary: ❑ Yes ❑ No ❑ N/A

Self – Care: **Hand Dominance:** ❑ Left ❑ Right

ADL's Prior to admission Dressing ❑ Indep ❑ SBA/Cueing ❑ Min Mod Max Assist x _____ ❑ Dependent
Bathing ❑ Indep ❑ SBA/Cueing ❑ Min Mod Max Assist x _____ ❑ Dependent

IADL'S Prior to admission Cooking I A D Grocery Shopping I A D Driving I A D Medication I A D
Cleaning I A D Banking I A D Laundry I A D

Equipment used prior to admission: _____

Current Status:

Dressing: U/E ❑ Max Assist ❑ Mod Assist ❑ Min Assist ❑ Supervision only ❑ Independent
L/E ❑ Max Assist ❑ Mod Assist ❑ Min Assist ❑ Supervision only ❑ Independent

Bathing: U/E ❑ Max Assist ❑ Mod Assist ❑ Min Assist ❑ Supervision only ❑ Independent
L/E ❑ Max Assist ❑ Mod Assist ❑ Min Assist ❑ Supervision only ❑ Independent

Current seating system (if applicable): _____

_____

Sitting Tolerance during the day (limiting factor(s) identified): _____

_____

Cognitive Status **	Not tested	Intact	Impaired	*** For Amputee patients – MoCA** _____
Orientation	❑	❑	❑	_____
Attention	❑	❑	❑	_____
Memory (short term)	❑	❑	❑	_____
Memory (long term)	❑	❑	❑	_____
Judgment	❑	❑	❑	_____
Insight	❑	❑	❑	_____
Frustration Tolerance	❑	❑	❑	_____

**** If there are cognitive issues please complete O-Log, Cog-Log and MoCA (as appropriate) - include scores with application**

Is there evidence of carry over between sessions: ❑ No ❑Yes _____

Is there evidence of new learning: ❑ No ❑Yes _____

Comments: _____

_____

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Part 3: To be completed by NURSING otherwise by Physician

Signature: _____ Phone: _____

Print Name: _____

**** PLEASE ATTACH MEDICATION RECORD TO APPLICATION**

CONTINENCE: Bowel: ❑No ❑Yes Bladder: ❑No ❑Yes Indwelling Catheter: ❑No ❑Yes
Condom Catheter: ❑No ❑Yes Intermittent Catheterization: ❑No ❑yes
Toileting Plan Initiated? ❑No ❑Yes (please specify - using urinal, bed pan, commode by bed, etc)

SPECIAL NEEDS:

Pressure Ulcers: ❑ No ❑ Yes Stage: _____ Size: _____ Location(s): _____
Wound Management: VAC: _____ Mattress: _____
Wound Dressings: ❑ No ❑ Yes If yes, specify: _____
Surgical Incision: ❑ No ❑ Yes If yes, specify: _____
Tracheotomy: ❑ No ❑ Yes If yes, specify: _____
Oxygen: ❑ No ❑ Yes If yes, specify: _____
Suction: ❑ No ❑ Yes If yes, specify: _____
I/ V Lines or Picc: ❑No ❑ Yes If yes, specify: _____
Pain: ❑ No ❑ Yes If yes, specify :_____
Capillary Blood Glucose Monitoring: ❑ No ❑ Yes If yes, specify: _____
Dialysis ❑ No ❑Yes ❑ Hemo ❑ Peritoneal ❑ If yes, specify schedule: _____
C Diff ❑ No ❑Yes If yes – current treatment _____
MRSA ❑ No ❑Yes If yes specify ❑ Contact ❑ Strict isolation Date of last swabs: _____
VRE ❑ No ❑Yes If yes specify ❑ Contact ❑ Strict isolation Date of last swabs: _____
Is individual on isolation for any other reason ❑ No ❑ Yes ❑ If yes, specify: _____
Sleep: Difficulty Sleeping ❑ No ❑ Yes if yes is sedation required, specify: _____
Behavior Issues: ❑ No ❑ Yes If yes specify below
❑ Physical Aggression ❑ Verbal Aggression ❑ Self Abuse ❑ Wandering ❑ Inapprop. Sexual Behavior
Other Issues - Specify: _____
_____
_____

Part 4: To be completed by a SOCIAL WORKER or other appropriate team member.

Signature: _____ Phone: _____

Print Name: _____

SOCIAL ASSESSMENT

Client Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Lives: ❑ Alone ❑ With Spouse ❑ Other _____

Substitute Decision Maker: _____

Relationship to Client: ❑ Spouse/partner ❑ Parent ❑ Sibling ❑ Son/Daughter ❑ Other: _____

Employed at Time of Injury/Event: ❑ No ❑ Yes

Type and Duration of Employment: _____

_____

Financial Supports: _____

_____

_____

_____

Family/Community Support Network (who, how available, how often interactions): _____

_____

_____

_____

_____

Additional Information (hobbies, interests): _____

_____

_____

_____

_____

Discharge Plan: To be started prior to application to rehab – indicate plan

_____

_____

_____

_____

_____

_____

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Part 5: To be completed by SPEECH LANGUAGE PATHOLOGIST or other appropriate team member.

Signature: _____ Phone: _____

Print Name: _____

COMMUNICATION: Language spoken: _____

Hearing: ❑ Intact, can hear routine conversation ❑ Intact with hearing aid ❑ Completely impaired

Vision: ❑ Intact ❑ Intact with visual aid ❑ Visual field deficit ❑ Double vision ❑ Completely impaired

Language expression: ❑ Intact ❑ Only able to express basic needs ❑ Uses gestures ❑ Completely impaired

Language comprehension: ❑ Intact ❑ Follows Basic Instruction ❑ Impaired

Comments: _____

_____

_____

_____

_____

Part 6: To be completed by DIETITIAN or other appropriate team member.

Signature: _____ Phone: _____

Print Name: _____

NUTRITION:

Current Diet: _____

_____

NG: _____ G-Tube: _____ J-Tube: _____ TPN: _____ PPN: _____

Dysphagia Assessment: ❑ No ❑ Yes If yes, date (YYYY/M/DD):

Concerns re: nutritional status: _____

_____

_____