Restorative Potential* means that there is reason to believe (based on clinical expertise and evidence in the literature where available) that the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's:

- Premorbid level of functioning
- Medical diagnosis/prognosis and co-morbidities (i.e., Is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
- Ability to participate in and benefit from rehabilitative care within the context of the patient's specific functional goals and direction of care needs.

Note:
Determination of whether a patient has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.

Rehabilitative Care Alliance Definitions Task Group.
Definitions Framework for Bedded Levels of Rehabilitative Care (December 2014)

Admission Criteria	Information recommended in RM&R application
Premorbid level of functioning	Describe the level of independence in basic and instrumental activities of daily living. Please include the amount of support received. Describe premorbid cognitive status. Describe patient's support systems and/or the role/ availability of caregiver during rehab process and upon discharge home.
Cognitive Impairment	Describe patient's general mental status (orientation, attention, short or long-term memory, ability to direct care). Describe patient's ability to follow 2 step instructions (example) Describe example(s) of information retention/ carryover, if able to observe Describe management strategies acute care has implemented that work for patients. ***If post-op delirium:*** Please describe the course of recovery (evidence of resolution). ***If dementia:*** Please describe the level of impairment (severity), any behaviours with considerations of time of day, management strategies.
Level of Participation	Describe time period and activities that patient participate in acute care.
Weight-bearing status	Describe lower extremity and/or upper extremity weight-bearing status, plan and timing of weight-bearing status progression, if available. Describe patient's level of participation/activities with weight-bearing status. Indicate rationale (e.g., clinical indication) why a patient is non-weight-bearing

GTA REHAB Network

Cross Sector Hip Fracture Task Group

New Referral Process Hip Fracture Initiative

INFORMATION RECOMMENDED WHEN COMPLETING RM&R REHAB/LTLD APPLICATIONS FOR HIP FRACTURE

Purpose of this document:
For acute care referral source to use a guide to minimize 'Requests for Information' during Rehab/LTLD application process that delay the referral response and application/ transition process.

General recommendations when completing applications
- Demonstrate patient's willingness to participate and abilities through facts.
- Provide information recommended for each admission criteria, where possible.
- Be transparent about risk situations

March 30, 2015 version

Patient Medical Needs Required	Information recommended in RM&R application
Bariatric Equipment Needs	Please describe height and weight. Please describe type of equipment(s) patient will need, currently used and measurements involved (e.g., wheelchair seat width, depth or height).
Bilevel Positive Airway Pressure (BiPAP) machine	Document patient's knowledge and level of independence in managing BiPAP machine. Document patient has own BiPAP machine. Describe if new or chronic, and if Respiratory Therapy intervention is needed.
Blood Transfusion	Describe blood type, anticipated time period when blood transfusion might occur (e.g., every 6 weeks etc.), and if it is part of routine care.
Cancer-Related Diagnosis and Therapy (e.g., Chemotherapy and/or Radiation Therapy)	Describe if cancer is active or remote, if patient has any planned/pending cancer-related treatment during rehab stay. ***If cancer is active:*** document if condition is new and prognosis (if known). ***If receiving chemotherapy &/or radiation therapy:*** Document if or will be receiving any of these treatment, the frequency and duration of treatment(s), and if required to travel off-site. Describe transportation plans if treatment requires travelling offsite. Describe patient's rehab participation and tolerance in acute care.
Continuous Positive Airway Pressure (CPAP) machine	Describe if new or pre-existing Document patient's knowledge and level of independence in managing CPAP machine. Document patient has own CPAP machine.
Dialysis: Hemodialysis	Describe if patient has physical endurance to travel to/from dialysis centre. Describe frequency/days for dialysis.
Dialysis: Peritoneal Dialysis	Describe patient's level of participation in dialysis care. Describe frequency/days for dialysis.
Enteral Feeds: Gastrojejunal (GJ) Tube	Describe if acute (new) or if patient was managing pre-admission. Specify the formula type and rate of feeds.
Enteral Feeds: Nasogastric (NG) Tube	Describe the planned time when NG tube is to be removed. Describe patient's level of participation in NG tube care. Specify the formula type and rate of feeds.
Enteral Feeds: Total Parenteral Nutrition (TPN)	Specify the formula type of rate of feeds.
Infectious Disease: Active Tuberculosis (TB) and other active airborne respiratory illness	Specify type of airborne respiratory illness, if active, recommended plan of care and anticipated prognosis.

Patient Medical Needs Required	Information recommended in RM&R application
Infectious Disease: Non-airborne requiring isolation	Specify type of infectious disease, requirement of isolation, and recommended plan of care.
Intravenous (IV) Therapy	Document the specific type of intravenous lines patient requires. Describe suggested treatment/follow up plan, and rationale for antibiotic therapy (if applicable).
(Supplemental) Oxygen Requirements	Document oxygen requirements rest and with activity. Describe patient's functional abilities/tolerance with oxygen level required. Describe if oxygen requirement is new or pre-existing. Please describe oxygen equipment/human resources required (e.g., rebreather, optiflow, Respiratory Therapist)
Ostomies	Describe if acute/chronic
Psychiatric episode (history of diagnosis)	Document if diagnosis/condition is stable or not, medication(s) to manage condition. ***If psychiatric episode occurred while in acute care:*** Describe the clinical course, patient's symptom presentation, management strategies suggested, suggested follow-up care/appointment. Include psychiatrist consultation notes in referral.
Specialty Mattress	Please describe rationale of need for pressure redistribution mattress, the type of mattress currently being used and recommended.
Suctioning	Please describe how often patient requires suctioning (e.g., hourly or as required), and level of independence in suctioning.
Tracheostomies: Cuffed	Describe if acute (new), stability of patient, patient's level of participation in activities with cuffed tracheostomy
Tracheostomies: Cuffless	Describe if acute (new) or if patient was managing pre-admission. Describe if patient able to cough up secretions independently and the level of independence in suctioning.
Urinary Catheters	Describe if new or chronic, type of catheter required, prognosis if catheter is permanent or temporary, any medical follow-up care scheduled
Wound Care	Document type of wound (i.e., surgical, pressure ulcer), the location and size of the wound (depth and width), stage of pressure ulcer, and wound care plan (e.g., dressing type and frequency dressing changed). Describe if wound is chronic, progression of healing, and management strategies. Document if VAC therapy is needed. Document time to complete dressing.