

Toronto eStroke Rehab RM&R System
ACUTE CARE TO OUTPATIENT REHAB REFERRAL FORM

Please complete all fields and send referral electronically through **eStroke** or fax a copy of this form to the stroke rehab program if outside of Toronto.

Note: Referrals to community programs require the ATTENDING physician's name and phone number

CLIENT DETAILS			
Patient's First Name		Last Name	
Responsible Person*:			
Health Card Number *		Version	Expiry Date
Province/Territory Issuing Health Card		Referral Provider	
DEMOGRAPHICS			
Patient DOB		YYYY-MM-DD	
MRN			
Does client have a permanent address? <input type="checkbox"/> Y <input type="checkbox"/> N			
Patient's Home Address		City	Province
Postal Code		Phone Number	
Does the patient have an alternate contact? <input type="checkbox"/> Y <input type="checkbox"/> N			
Alternate Contact Name		Phone Number	Relation to patient
Current Location*:			
SUPPLEMENTARY INFORMATION			
When was patient admitted to acute care? YYYY-MM-DD*			
Patient's Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other			
Bed Offer Contact: First Name		Last Name	Email address
Does the patient have a Primary Care Provider? <input type="checkbox"/> Y <input type="checkbox"/> N			
Primary Care Provider's Name			
Primary Care Provider's Contact Information (phone or fax)			
Primary Language Spoken <input type="checkbox"/> English <input type="checkbox"/> Other		If other indicate Primary Language Spoken	
Speaks, Understands English <input type="checkbox"/> Yes <input type="checkbox"/> No		Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Premorbid Vocational Status (before this encounter) (amended from CIHI-NRS)			
<input type="checkbox"/> Full time or 30 hrs/week	<input type="checkbox"/> Part-time <30 hrs/week	<input type="checkbox"/> Adjusted/modified work	<input type="checkbox"/> Student <input type="checkbox"/> Volunteer
<input type="checkbox"/> Retired	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Homemaker <input type="checkbox"/> Don't know
Type of vocation (Describe)			
Educational Level (choose HIGHEST level completed)			
<input type="checkbox"/> High School Grade 12	<input type="checkbox"/> High School Grade 13	<input type="checkbox"/> College Diploma	<input type="checkbox"/> University Degree
<input type="checkbox"/> Masters Degree	<input type="checkbox"/> Doctoral Degree	<input type="checkbox"/> Don't know	<input type="checkbox"/> Other (list)
Is patient ready to transfer to rehab within the next 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No		If early referral (e.g. patient to be weaned off of NG tube, IV out, dates) provide details in text box if special needs expected to resolve before discharge	
If NO, indicate Anticipated date ready for rehab or ready for transfer to rehab* MM/DD/YYYY			
Rehab Setting Type <input type="checkbox"/> Outpatient Rehab Apply to 1 outpatient rehab facilities based on closest to home/discharge destination and/or patient preference.			
Additional Referral Comments			

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ACUTE TO OUTPATIENT REHAB REFERRAL FORM
ACUTE MEDICAL ASSESSMENT



Patient's Name:			
Physician or Physician Designate or Nurse Practitioner to complete Complete the medical section in as much detail as possible. Fields marked * are mandatory			
Date of Stroke Onset (or Date Last Seen Normal) *		YYYY-MM-DD	
First Stroke? * <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Previous Stroke YYYY-MM-DD		
Type of Stroke* (current stroke)	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Transforming to Hemorrhagic		
Stroke Location (most recent CT/MRI)	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Frontal <input type="checkbox"/> Parietal <input type="checkbox"/> Occipital <input type="checkbox"/> Temporal <input type="checkbox"/> Internal Capsule	<input type="checkbox"/> Basal ganglia <input type="checkbox"/> Thalamus <input type="checkbox"/> Cerebellum <input type="checkbox"/> Brainstem
Deficits related to <u>Current</u> Stroke			
<input type="checkbox"/> L Hemiparesis <input type="checkbox"/> R Hemiparesis <input type="checkbox"/> No Paresis <input type="checkbox"/> Aphasia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Apraxia <input type="checkbox"/> Neglect <input type="checkbox"/> Ataxia <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Visual Deficits <input type="checkbox"/> Visual Perceptual Deficits <input type="checkbox"/> Other (provide additional details):			
Previous CT or MRI Findings	<input type="checkbox"/> None <input type="checkbox"/> Evidence of previous infarcts <input type="checkbox"/> Sub cortical white matter changes - Mild <input type="checkbox"/> Sub cortical white matter changes - Moderate <input type="checkbox"/> Sub cortical white matter changes - Severe		
Mechanism of Stroke	<input type="checkbox"/> Carotid Stenosis Required Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No (IF YES, include details in surgical history below) <input type="checkbox"/> Cardioembolic <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Dilated Cardiomyopathy or other structural/wall movement abnormality <input type="checkbox"/> Valvular problem <input type="checkbox"/> Dissection <input type="checkbox"/> Carotid <input type="checkbox"/> Vertebral <input type="checkbox"/> Small Vessel Thrombosis <input type="checkbox"/> Auto Immune (include details in co-morbidity section below) <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Provide details)		
Treatment Received	<input type="checkbox"/> Thrombolysis (e.g. t-PA) <input type="checkbox"/> Endovascular Treatment (include details in surgical history below)		
Specific Conditions Impacting On Rehab Potential			
<input type="checkbox"/> None on this list <input type="checkbox"/> Angina <input type="checkbox"/> Coronary Artery Bypass Surgery or Stenting Procedure <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Amputation <input type="checkbox"/> Asthma <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Cerebral Vasculitis <input type="checkbox"/> Other (list):			

Patient's Name:						
<p>Charleson Comorbidities Index</p> <p><input type="checkbox"/> No Comorbidities on THIS List</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> (1) Myocardial Infarct <input type="checkbox"/> (1) Congestive Heart failure <input type="checkbox"/> (1) Peripheral Vascular disease <input type="checkbox"/> (1) Cerebrovascular disease <input type="checkbox"/> (1) Dementia <input type="checkbox"/> (1) Chronic pulmonary disease <input type="checkbox"/> (1) Connective tissue disease <input type="checkbox"/> (1) Ulcer <input type="checkbox"/> (1) Mild liver disease </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> (1) Diabetes <input type="checkbox"/> (2) Hemiplegia (Pre-existing) <input type="checkbox"/> (2) Moderate or severe renal disease <input type="checkbox"/> (2) Diabetes with end organ damage <input type="checkbox"/> (2) Any tumor <input type="checkbox"/> (2) Leukemia <input type="checkbox"/> (2) Lymphoma <input type="checkbox"/> (3) Moderate or severe liver disease <input type="checkbox"/> (3) AIDS </td> </tr> </table> <p>Other Comorbid Conditions of Significance (list): _____</p>			<input type="checkbox"/> (1) Myocardial Infarct <input type="checkbox"/> (1) Congestive Heart failure <input type="checkbox"/> (1) Peripheral Vascular disease <input type="checkbox"/> (1) Cerebrovascular disease <input type="checkbox"/> (1) Dementia <input type="checkbox"/> (1) Chronic pulmonary disease <input type="checkbox"/> (1) Connective tissue disease <input type="checkbox"/> (1) Ulcer <input type="checkbox"/> (1) Mild liver disease	<input type="checkbox"/> (1) Diabetes <input type="checkbox"/> (2) Hemiplegia (Pre-existing) <input type="checkbox"/> (2) Moderate or severe renal disease <input type="checkbox"/> (2) Diabetes with end organ damage <input type="checkbox"/> (2) Any tumor <input type="checkbox"/> (2) Leukemia <input type="checkbox"/> (2) Lymphoma <input type="checkbox"/> (3) Moderate or severe liver disease <input type="checkbox"/> (3) AIDS		
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<p>The total sum of the comorbidities above reflects the patient's ability to tolerate rehabilitation. Patients with scores > 3 may not tolerate rehabilitation</p>						
<p>Previous Psychiatric History * No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, mandatory to describe history and status in comment box</p>						
<p>Current Psychiatric Diagnosis * No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, mandatory to specify diagnosis and status in comment box</p>						
<p>Surgical History/Planned Surgery</p> <p>Surgeries No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>List surgeries during this hospitalization/planned surgery with date: _____</p> <p>Complications/care plan resulting from surgery: _____</p>						
<p>Stroke Workup</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> <p>Echocardiogram</p> <input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ___/___/___ yy/mm/dd </td> <td style="width: 25%; vertical-align: top;"> <p>Holter Monitor</p> <input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ___/___/___ yy/mm/dd </td> <td style="width: 25%; vertical-align: top;"> <p>Carotid Imaging</p> <input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ___/___/___ yy/mm/dd </td> <td style="width: 25%; vertical-align: top;"> <p>*Secondary Prevention Clinic</p> <input type="checkbox"/> Booked * ___/___/___ yyyy/mm/dd <input type="checkbox"/> Referred </td> </tr> </table>			<p>Echocardiogram</p> <input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ___/___/___ yy/mm/dd	<p>Holter Monitor</p> <input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ___/___/___ yy/mm/dd	<p>Carotid Imaging</p> <input type="checkbox"/> Done <input type="checkbox"/> Not indicated <input type="checkbox"/> Booked ___/___/___ yy/mm/dd	<p>*Secondary Prevention Clinic</p> <input type="checkbox"/> Booked * ___/___/___ yyyy/mm/dd <input type="checkbox"/> Referred
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Referring Physician's Name	Date	YYYY-MM-DD				
Attending Physician's Name*	Date	YYYY-MM-DD				
Referring Nurse Practitioner's Name	Date	YYYY-MM-DD				

Toronto eStroke Rehab RM&R System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
SOCIAL INFORMATION



Patient's Name:		
FINANCES		
Who manages the patient's FINANCES NOW? <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Don't Know		
If OTHERS, list contact information contact person, FINANCES		
Name		
Relationship to patient <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
PERSONAL CARE		
Who manages the patient's PERSONAL CARE decisions now? <input type="checkbox"/> Self <input type="checkbox"/> Others		
If others, list contact information <input type="checkbox"/> Same as contact person, FINANCES OR		
Contact Person, PERSONAL CARE decisions		
Name		
Relationship to patient <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
SUBSTITUTE DECISION MAKER		
Document if patient retains any of the following		
<input type="checkbox"/> A substitute decision maker <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Public Guardian/Trustee <input type="checkbox"/> N/A		
Contact information if applicable		
<input type="checkbox"/> Same Contact, FINANCES <input type="checkbox"/> Same Contact, PERSONAL CARE <input type="checkbox"/> Other, see below.		
If OTHER list contact information		
Name		
Relationship to patient <input type="checkbox"/> Spouse <input type="checkbox"/> partner <input type="checkbox"/> son or daughter <input type="checkbox"/> sibling <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> appointed <input type="checkbox"/> other		
Address		Postal Code
Daytime Phone		Evening Phone
Financial Information Adapted from CIHI NRS		
<input type="checkbox"/> WSIB <input type="checkbox"/> Private Insurance <input type="checkbox"/> OAS <input type="checkbox"/> Legal Settlement <input type="checkbox"/> Ontario Works <input type="checkbox"/> Self-employed <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Canadian Pension <input type="checkbox"/> No income <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Veteran <input type="checkbox"/> ODSP <input type="checkbox"/> EI		
Responsibility for Payment Source: CIHI NRS		
<input type="checkbox"/> OHIP <input type="checkbox"/> Federal Government <input type="checkbox"/> IFH (Interim Federal Health Grant) <input type="checkbox"/> Inter-provincial Insurance Plan <input type="checkbox"/> Insured/Self Pay <input type="checkbox"/> Other Payment Sources <input type="checkbox"/> WSIB <input type="checkbox"/> Uninsured/Self Pay <input type="checkbox"/> Unknown		
If insurance payment		Claim #
Name of insurer		Certificate #
Group number		Policy #

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
SOCIAL INFORMATION (cont'd)



Patient's Name:		
Marital Status:		
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	
<input type="checkbox"/> Common Law	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Separated		
*Home living situation, living with: (Adapted from CIHI-NRS)		
<input type="checkbox"/> Spouse/partner <input type="checkbox"/> Family (including extended family) <input type="checkbox"/> Lives with others (includes retirement home or group home WITH supportive services, supportive living environment, live-in caregiver, LTC) <input type="checkbox"/> Living alone (includes retirement home with NO supports available) <input type="checkbox"/> Other (includes rooming house/boarding house/group home/shelter/hostel with NO supportive services available) * if this ticked, mandatory to complete below		
Caregiver support can be provided by:		
<input type="checkbox"/> Spouse/partner	<input type="checkbox"/> Roommate or Others	
<input type="checkbox"/> Family (including extended family)	<input type="checkbox"/> N/A	
Premorbid additional support required:		
<input type="checkbox"/> Attendant care <input type="checkbox"/> Home support <input type="checkbox"/> Privately-funded care <input type="checkbox"/> None		
Provide information on premorbid function and existing supports required pre-admission.		
Can caregiver currently provide support with:	ADL*	IADL*
<input type="checkbox"/> N/A, patient does not have a caregiver		
Willing	<input type="checkbox"/>	<input type="checkbox"/>
Able	<input type="checkbox"/>	<input type="checkbox"/>
Available days	<input type="checkbox"/>	<input type="checkbox"/>
Available evenings	<input type="checkbox"/>	<input type="checkbox"/>
Comments caregiver support Indicate post-rehab supports available and/or plans in progress (e.g. family to live with patient, able to assist, able to purchase equipment, securing retirement home):		
Present accommodation:		
<input type="checkbox"/> House	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Residential Group Home	<input type="checkbox"/> Homeless	
<input type="checkbox"/> Apartment Building	<input type="checkbox"/> Other (list):	
<input type="checkbox"/> Rooming house		
Describe accommodation barriers that must be dealt with in order for patient to return home:		
<input type="checkbox"/> Stairs into dwelling	<input type="checkbox"/> No barriers	
<input type="checkbox"/> Stairs to bathroom	<input type="checkbox"/> Don't know	
<input type="checkbox"/> Stairs to bedroom	<input type="checkbox"/> Other (list):	
Expected Discharge Destination Post Rehab:		
<input type="checkbox"/> Home <input type="checkbox"/> Home, CCAC +/- paid help <input type="checkbox"/> Assisted Living (seniors apt building, retirement home) <input type="checkbox"/> LTC/CCC <input type="checkbox"/> Shelter/Hostel <input type="checkbox"/> Don't know		
Comment:		
Completed by:	Date:	

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
ALPHAFIM® INSTRUMENT



PT/OT to complete

- The AlphaFIM® Instrument provides a snapshot of the patient's burden of care and helps assist in decision making for rehab referrals. Note: The most current details relating to status and management of bowel and bladder continence are provided in the nursing section of the referral
- Consultation with other team members required to ensure lowest score in 24 hours
- Day 3 (or earlier) AlphaFIM® Instrument scores are entered into the eStroke database for patients referred to stroke rehab within 7 days of stroke onset. In addition, a second score may be added to the referral if:
 - there has been a significant change in patient status
 - referrals are initiated or updated after Day 7

Patient's Name	DOB	YYYY-MM-DD
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Tester Name	Date of Assessment	YYYY-MM-DD
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AlphaFIM® scores completed:
 On or by day 3 (First Assessment)
 Second Assessment
 Third Assessment
 Fourth Assessment

Type of Stroke: (tick one)
 Stroke R body
 Stroke L body
 Stroke no paresis
 Stroke bilateral
 Other stroke

Complete the AlphaFIM® Instrument items indicated below based on the distance the patient can currently walk.

Patient walks less than 150ft	Patient walks 150ft or more		AlphaFIM® Instrument Rating Levels
Eating	Transfers: Bed Chair		Note: leave no blanks Enter 1 if not able to test an item due to risk No HELPER 7. Complete Independence (no device, timely, safely) 6. Modified Independence (device, not timely, or not safely) Helper <i>Modified Dependence (performs 50% or more of task)</i> 5. Supervision (patient performs 100% of the effort) 4. Minimal Assistance (patient performs 75% or more of the effort) 3. Moderate Assistance (patient performs 50% - 74% of the effort) Complete Dependence (performs less than 50% of task) 2. Maximal Assistance (patient performs 25% - 49% of the effort) 1. Total Assistance (patient performs < 25% of the effort)
Grooming	Walk		
Bowel Management	Bowel Management		
Transfers: Toilet	Transfers: Toilet		
Expression	Expression		
Memory	Memory		

Comments:

Projected Scores from AlphaFIM® Instrument software at www.udsmr.org (select software portal, AlphaFIM® software).

If bowel scored 7 indicate in comment section if due to:
 a) Absence of bowel movement in last 24 hours
 b) Patient fully continent.

FIM® 13 Raw Motor	Projected scores are calculated using the AlphaFIM® Instrument software.
FIM® 5 Raw Cognition	
FIM® 13 Rasch Motor	
FIM® 5 Rasch Cognition	
FIM® Motor Range	
FIM® Cognition Range	
FIM® Walking Range	
Help Needed	

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Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
ORPINGTON PROGNOSTIC SCALE



Orpington Prognostic Scale TIPS for Completion document available as a link on this page or in REFERENCES Section

PT/OT to complete		
Orpington Prognostic Scale: Grade the patient by CIRCLING the appropriate scores below.		
Motor deficit in arm Lying supine, patient flexes shoulder to 90 degrees and is given resistance		<p>Total Orpington Prognostic Score</p> <p>1.6 + Motor score + Proprioception + Balance score + Cognition Score = _____</p>
MRC grade 5 (normal power)	0	
MRC grade 4 (diminished power)	0.4	
MRC grade 3 (movement against gravity)	0.8	
MRC grade 1-2 (movement with gravity eliminated or trace)	1.2	
MRC grade 0 (no movement)	1.6	
Proprioception (eyes closed) Locates affected thumb		<p>Interpretation of Stroke Severity Score:</p> <p>< 3.2 score = 3 minor stroke 3.2-5.2 score = 1 moderate stroke > 5.2 score = -1 major stroke</p>
Accurately	0	
Slight difficulty	0.4	
Finds thumb via arm	0.8	
Unable to find thumb	1.2	
Balance		<p>Scoring Cognition (Score out of 10): Mental score 10 = 0.0 Mental score 8-9 = 0.4 Mental score 5-7 = 0.8 Mental score 0-4 = 1.2</p>
Walks 10 feet without help	0	
Maintains standing position	0.4	
Maintains sitting position	0.8	
No sitting balance	1.2	
Cognition (Hodgkins Mental test): Can the patient recall..... Hodgkins Mental Test score: options are 0.0, 0.4, 0.8, 1.2		<p>Strategies for Aphasic Patients</p> <ul style="list-style-type: none"> • Provide 3 choices written down if necessary for each question – allow patient to point to answer • Provide a yes/no answer to a question and provide sufficient time for patient to answer e.g.; <ul style="list-style-type: none"> ○ Patients age – provide 3 choices and yes/no answer ○ Time – provide 3 choices and yes/no answer or use a clock and allow patient to point
1. Age of the patient	1	
2. Time (to the nearest hour)	1	
<i>(Prompt by you) I am going to give you an address, please remember it and I will ask you later: 42 West St</i>		
3. Name of hospital	1	
4. Year	1	
5. Date of birth of patient	1	
6. Month	1	
7. Years of Second World War (1939-1945) (approximate range okay)	1	
8. Name of President of the United States	1	
9. Count backwards from 20	1	
10. What is the address I asked you to remember?	1	

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
ORPINGTON PROGNOSTIC SCALE



Patient's Name:		
PT/OT to complete	Tester Name:	Date:
Stroke Modifiers	-1 <input type="checkbox"/> Coma at onset of stroke	
	+1 <input type="checkbox"/> Pure motor deficit	
	-1 <input type="checkbox"/> Visuospatial deficit	(Draw a clock face with the time of 10 minutes after 11 am, OR if the patient cannot draw, have patient observe a clock and tell the time, or complete line bisection test)
	+1 <input type="checkbox"/> Lacunar infarct	Parietal symptoms may include: <ul style="list-style-type: none"> • Anosognosia: ignorance or lack of awareness of deficit • Finger Agnosia: inability to name individual fingers such as the thumb or finger • Right-to-left Confusion: inability to tell whether the hand, foot or arm of the examiner is on the right or left side of the body • Aculculia: impairment of simple arithmetic • Agraphia: impairment of ability to write
	-2 <input type="checkbox"/> Bihemispheric deficit	
	-1 <input type="checkbox"/> Dysphagia	
	-2 <input type="checkbox"/> Parietal Symptoms	
-1 <input type="checkbox"/> Incontinence persists 2 weeks or longer post stroke	Does the patient have neurologic bladder incontinence (i.e. unrelated to inability to get to a toilet in time as a result of weakness) that persists for more than 2 weeks post stroke onset?	
Patient Modifiers	+2 <input type="checkbox"/> Age <55 years	
	-3 <input type="checkbox"/> Severe cardiovascular disease CCS Class III-IV and/or NYHA Class III-IV Angina	Confirm the existence of severe cardiac or respiratory disease or symptomatic PVD disease with NP or MD
	-3 <input type="checkbox"/> Severe respiratory disease Dyspnea Class III-IV	
	-1 <input type="checkbox"/> Coexistent symptomatic PVD	
	-1 <input type="checkbox"/> Poor premorbid functioning	
Time Modifiers	+2 <input type="checkbox"/> Time elapse since stroke < 2 weeks	
	0 <input type="checkbox"/> Time elapsed since stroke = 2-4 weeks	
	-1 <input type="checkbox"/> Time elapsed since stroke = 4-8 weeks	
	-2 <input type="checkbox"/> Time elapsed since stroke > 8 weeks	
Modified Orpington Score (Sum of modifiers PLUS stroke severity score from previous page) If final score is ≥ 0 Client is a candidate for active IP rehab programs or home rehab. If final score is < 0 Client is a candidate for low tolerance rehabilitation programs		
If unable to complete the Orpington, Indicate reason		If unable to complete the Orpington indicate reason. Consultation with SLP may be required to complete the Orpington for patients with aphasia

Patient's Name	
OT/PT to complete	Tester's Name Date:
Was a COPM completed for this episode? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the COPM If NO, Unable to complete COPM (provide reason) <input type="checkbox"/> Language barrier with no translation available <input type="checkbox"/> Aphasia without available support <input type="checkbox"/> COPM© not currently implemented in organization <input type="checkbox"/> Other (list below): If Other select – Describe reason unable to complete	
Tester First Name	Last Name
Tester Phone Number	Extension
Completed:	Assessment Date YYYY-MM-DD
Scoring PERFORMANCE (How would you rate the way you do this activity now?) 1 = not able to do it at all, 10 = able to do it extremely well Satisfaction (How satisfied are you with the way you do this activity now?) 1 = not satisfied at all, 10 = extremely satisfied	
How many Occupational Performance Problems has the patient identified?	
Occupational Performance Problem 1 Describe: Rate Importance:	Up to 5 Occupational Performance Problems can be identified and rated
Occupational Performance Problem 2 Describe: Rate Importance:	
Occupational Performance Problem 3 Describe: Rate Importance:	
Occupational Performance Problem 4 Describe: Rate Importance:	
Occupational Performance Problem 5 Describe: Rate Importance:	
Additional Information	
How many additional Occupational Performance Problems has the patient identified? – Maximum of 10	
Notes and Observations	

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
FUNCTIONAL ASSESSMENT



Patient's Name:			
PT/OT to complete		Tester Name:	
		Date:	
Functional Status* - Comment on current function and patient's PROGRESS (functional gains) since admission and implications for future rehab:			
Ability to participate – current status:			
Physical Activity tolerance *		Sitting tolerance *	
<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> Supported	<input type="checkbox"/> Unsupported	<input type="checkbox"/> 15-30 minutes
<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 30-60 minutes
<input type="checkbox"/> > 1 hour	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> >1 hour
	<input type="checkbox"/> >1 hour	<input type="checkbox"/> >1 hour	
Frequency of activity/therapy treatment tolerated: <input type="checkbox"/> Daily <input type="checkbox"/> Multiple times / day <input type="checkbox"/> 2-3 x per week <input type="checkbox"/> Weekly			
Comment on changes or limitations in PARTICIPATION during this admission and implications for future rehab:			
Motivation to participate in rehabilitation (choose One)			
<input type="checkbox"/> Demonstrates motivation to participate in rehab (regular attendance and involvement, cooperation)			
<input type="checkbox"/> Usually motivated to participate, occasional frustration apparent			
<input type="checkbox"/> Motivated to participate but attendance, involvement or cooperation irregular			
Is the patient experiencing shoulder pain? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Comment:			
Can patient take direction, execute and RETAIN verbal OR written OR visual instructions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Anticipated Progress: √ the column matching anticipated independence by end of next rehab setting			
	Independent with or without aids	Minimal assistance	Moderate to maximal assistance
Locomotion			
Transfers			
ADL			
IADL			
Other (list)			
Additional services:			
<input type="checkbox"/> Pain management			
<input type="checkbox"/> Self-care & mobility assessment prescription			

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
FUNCTIONAL ASSESSMENT – con't



Patient's Name:			
PT/OT to complete		Tester Name:	
		Date:	
Visual Perceptual Status – Attention* <input type="checkbox"/> Normal <input type="checkbox"/> Mild Inattention <input type="checkbox"/> Moderate Inattention <input type="checkbox"/> Severe Inattention		Visual Perceptual status* <input type="checkbox"/> Body neglect <input type="checkbox"/> Reduced depth perception <input type="checkbox"/> Affected spatial awareness/skills <input type="checkbox"/> Apraxia <input type="checkbox"/> Visual field deficit	
Cognition – Attention* <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	Memory * <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	Judgment * <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test	Executive Functioning * <input type="checkbox"/> No deficit <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unable to test
MoCA Score completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes indicate score ___/30		A score <26 warrants ongoing cognitive assessment	
Comments on COGNITION - Describe Impact of Cognition and Perception on Function <u>during this admission</u>* <p>If any of mild/moderate/severe checked, mandatory to complete text box</p>			
In your opinion, rate the patient's progress during this admission <input type="checkbox"/> Marked progress <input type="checkbox"/> Moderate progress <input type="checkbox"/> Minimal progress <input type="checkbox"/> Patient has plateaued in progress <input type="checkbox"/> Patient is too acute to measure progress <input type="checkbox"/> Other (comment)			
Comment, RATE OF PROGRESS			

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM
COMMUNICATION AND SWALLOWING



Patient's Name:			
SLP to complete	Tester Name:	Date:	
Is Speech Language Pathologist involved with this patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
Communication Disorder <input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Both new and old	Speech* <input type="checkbox"/> Adequate <input type="checkbox"/> Receptive aphasia <input type="checkbox"/> Expressive aphasia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Apraxia <input type="checkbox"/> Cognitive communication deficit <input type="checkbox"/> Voice disorder	Communicates <input type="checkbox"/> Adequately <input type="checkbox"/> With Difficulty <input type="checkbox"/> Unable	
Current status and changes in <u>COMMUNICATION</u> during this admission			
Changes in Communication*			
Swallowing Disorder * <input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Old <input type="checkbox"/> Both new and old	Phase Swallowing Affected <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Oral <input type="checkbox"/> Both <input type="checkbox"/> Esophageal		
Current status and changes in <u>SWALLOWING</u> during this admission and implications for future rehab:*			
Has videofluoroscopy been performed on this admission? <input type="checkbox"/> Yes <input type="checkbox"/> No		Repeat/videofluoroscopy recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diet * <input type="checkbox"/> Regular <input type="checkbox"/> NPO <input type="checkbox"/> NG <input type="checkbox"/> GJ <input type="checkbox"/> J <input type="checkbox"/> G	Adjusted diet: solids <input type="checkbox"/> Minced diet <input type="checkbox"/> Pureed diet <input type="checkbox"/> Dental soft diet <input type="checkbox"/> Snacks only <input type="checkbox"/> Other (list below):	Adjusted diet: liquids <input type="checkbox"/> Thin liquids <input type="checkbox"/> Nectar thick liquids <input type="checkbox"/> Honey thick liquids <input type="checkbox"/> Pudding <input type="checkbox"/> Sips of water only <input type="checkbox"/> G-tube feeds <input type="checkbox"/> Other (list below):	
Changes in DIET during this admission and implications for future rehab			
Anticipated Progress: <input checked="" type="checkbox"/> the column matching anticipated level of independence by end of next rehab setting	Independent with or without aids	Minimal assistance	Moderate to maximal assistance
Communication			
Feeding			
Impact of communication disorder(s) on behavior <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Speech, language and diet comments:			

Toronto Stroke Rehab Referral System

ACUTE TO OUTPATIENT REHAB REFERRAL FORM

COMMUNITY REFERRAL



Note: Only complete this section if the patient is being referred to rehab in the community

Reason for referral – services, programs and transportation (check ALL that apply)

- | | |
|---|--|
| <input type="checkbox"/> Behavioural rehab | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Caregiver peer support | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Clinical dietitian | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Life skills training | <input type="checkbox"/> Social work |
| <input type="checkbox"/> Medical specialist | <input type="checkbox"/> Speech language pathology |
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Supportive independent living |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Transitional living |
| <input type="checkbox"/> Vocational rehab | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Restore continence | <input type="checkbox"/> Manage Depression |
| <input type="checkbox"/> Self care & mobility assessment prescription | <input type="checkbox"/> Home management skills |
| <input type="checkbox"/> Restore avocation | <input type="checkbox"/> Other (list) _____ |

Transportation (check ALL that apply)

- Independent
- Accompanied by friend/family
- Accompanied by attendant
- Uses Wheel Trans
- Uses public transport
- Uses other (list) _____

Additional Referral Comments: