ProvidencePlace

Geriatric Assessment & Rehabilitation Referral

100-2nd Ave NE Moose Jaw SK S6H 1B8
Phone: 1-306-694-8815 Fax: 1-306-694-8879

Date	PHN
Client Name	
Phone	DOB dd/mm/yr
Address	
Physician	

Present Location of Patient:_____

Primary Diagnosis: _____

Surgery Date: _____**Follow up Date:**_____

Primary Contact: _____ Phone: _____

Aware of Referral: □ Yes □ No

□ Patient is deemed medically stable by primary physician and ready to transfer to GARU immediately.
Physician Signature: _____ **Date**: _____

NURSING

Medical History

□ Diabetes	□ Renal Failure	□ Seizures	TLR Status:
□ COPD	□ Dialysis: □ chronic □ acute	□ Surgical Date:	
□ CAD	□ Dementia	□ Other:	

Must meet all of the following criteria to go to GARU:
Weight-Bearing Status: □ NWB □ PWB □ WBAT □ TTWB
It is expected that the client can return home with current weight-bearing status? Y/N
For acute care patient referrals:
□ Bloodwork within normal limits for patient
□ Hgb greater than 90 and asymptomatic (if less than 90 physician to physician communication required)
Hgb: _____ Date: _____ Physician to Physician Communication: _____
For all referrals:
□ Vital signs within normal limits for patient BP_____ P _____ R_____ O_2 Sat _____ T_____ Wt _____
Absence of: □ Nausea and vomiting □ Uncontrolled pain □ Diarrhea □ If C-diff toxin positive, no loose stools for 48 hours
Comments:_____
_____**Nurse Signature:** _____

Special Considerations – Please check if patient has any of: □ VAC or complex dressing □ PEG tube/feeds □ Trach
□ CVAD: type _____ □ Bariatric □ 0_2 use □ Home 0_2 □ Isolation Precautions: □ VRE □ MRSA □ C-diff □ ESBL

THERAPIES

□ Rehabilitation Referral

Must meet all of the following criteria to go to GARU:
□ cognitive: able to follow one-step instruction
□ recent significant functional decline(mobility/ADL/IADLs)
Explain: _____
□ requires longer than 2 weeks in inpatient rehab to optimize function
□ requires 2 or more specialties in order to optimize function (check all that apply):
- □ PT mobility, strength, balance, other: _____
- □ OT cognitive, ADL, IADL, other: _____
- □ SLP communication, swallowing, other: _____
- □ Social Work (client/family counselling)
- □ Dietician
- □ Other: _____

□ has demonstrated progression in therapy. Explain:
Function: _____
_____
Physical: _____
_____
□ Orpington attached for CVAs
Signature: _____ **Date:** _____

□ Complex Level of Care Assessment Referral

□ cognitive: able to follow one-step instruction
Assessment services previously accessed:
□ Home Care □ Comm. OP Therapy □ Adult day program
When: _____
Must try above options before using GARU referral
□ lives alone (or assisted living) and not coping (not PCH)
□ requires assessment of 3 or more of following in inpatient setting:
- □ cognitive function
- □ medication management
- □ ADLS
- □ Kitchen/cooking
- □ catheter/ostomy management
- □ diabetes management
- □ home environment assessment
- □ seating (wheelchair) assessment
- □ Toileting/incontinence management
- □ Investigation for frequent falls (1 or more/month)

□ **Patient/family aware assessment will not exceed 2-week stay**

Signature: _____ **Date:** _____