Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB*(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Specialized Geriatrics Inpatient Intake Referral

Complete and Fax to Glenrose Rehabilitation Hospital

Fax 780.735.8821 Phone 780.735.8820

For **Psychiatry Referral** please use Form18290 - Seniors Mental Health Integrated Referral
Incomplete forms will cause a delay in processing the referral.

Last Name	First	Gender ☐ Female ☐ Male
PHN	DOB *(yyyy-Mon-dd)*	Phone
Address	City/Town	Postal Code
Family Physician	Phone	Fax
Family Physician aware of referral	☐ Yes	☐ No
Contact Person	Relationship	Phone

Date *(yyyy-Mon-dd)*	Program Requested (*Please refer to Admisson Criteria)* ☐ Geriatric Short Stay Rehabilitation *(Unit 3D) (2-3 weeks)* ☐ Geriatric Assessment & Rehab.*(Units 3D/4C) (3-5 weeks)* ☐ Geriatric Cognitive and Behavioral *(Unit 4D) (5-7 weeks)*
Current Location of Patient	
Phone	Fax

Reason for Referral *(Please elaborate and be specific with this information)*

_____

_____

_____

Prior Living Situation

Lives with	☐ Spouse	☐ Alone	☐ Other_____
Informal Supports			
Formal Supports	☐ Home Care ☐ Meals on Wheels	☐ CHOICE ☐ Mental Health	☐ Day Program ☐ Other _____
Prior Living Setting	☐ Home ☐ Facility Living (LTC) Name of Facility _____	☐ Lodge ☐ Assisted Living (DAL/PAL)	☐ Seniors apartment
Anticipated Discharge Location	☐ Home ☐ Facility Living (LTC)	☐ Lodge ☐ Assisted Living (DAL/PAL)	☐ Seniors apartment

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Medical Status

- ☐ Medically stable
- ☐ Relevant diagnostic tests completed
- ☐ On precautions *(MRSA / VRE / C.Diff)* *(location)*_____
- ☐ Continent bowel
- ☐ Continent bladder
- ☐ Intermittent/Indwelling catheter _____
- ☐ IV/Clysis
- ☐ Oxygen _____ L/min.
- ☐ CPAP/BIPAP
- ☐ Dialysis
- ☐ Wound(s)
- ☐ Tracheostomy
- ☐ Feeding/Swallowing Impairment
- ☐ Current Nutrition Management/Diet
- ☐ Speech/Language Impairment

Behaviours *(check all that apply)*

- ☐ Anxious
- ☐ Resistive to Care
- ☐ Elopement Risk
- ☐ Withdrawn
- ☐ Paranoia
- ☐ Vocalizations
- ☐ Substance Abuse _____
- ☐ Agitation
- ☐ Disruptive to others
- ☐ Insomnia
- ☐ Depressed
- ☐ Hoarding
- ☐ Impulsive
- ☐ Aggression
- ☐ Wandering
- ☐ Sundowning
- ☐ Hallucinations
- ☐ Rummaging
- ☐ Disinhibition

Basic Activities of Daily Living (BADL)	Independent	Standby	1P	2P
Transfers				
Walking				
W/C Mobility				
Toileting				
Grooming/Dressing				
Eating				

Weight Bearing Status: ☐ U/E R _____L _____ ☐ L/E R _____L_____

Equipment Used

Recent Cognitive Assessment	Date
Recent GDS	Date

Other recent cognitive testing will be considered e.g. MOCA, EXIT.

Comments

_____

_____

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To be Completed by PT or OT only (*Note: walker users require partial weight bearing on ALL 4 limbs)*	(✓) Yes	(✓) No
Consistently demonstrates ability and motivation to participate in active rehabilitation?		
Has the patient ever refused to participate in any PT or OT session? If yes, why? _____		
Patient registers, retains and follows through with instruction during PT/OT?		
Demonstrates a sitting /activity tolerance of at least 2 hours?		
Has functional status improved with PT/OT intervention?		

Anticipated Rehab completed ☐ Within 2 - 3 weeks ☐ Within 3 – 5 weeks

Comments

Print Name	Professional Designation	Signature
Date	Phone	

Choose all that apply. Attach copies if available. Do not send information available on NetCare

- ☐ Medical History, Physician Orders and Progress Notes 3 – 4 prior, D/C Summary, Geriatric Assessment and/or Geriatric Consult(s) Notes
- ☐ Orthopedic Orders
- ☐ Goals of Care
- ☐ Personal Directive and/or Power of Attorney
- ☐ Allergies
- ☐ Current blood work results
- ☐ Other relevant tests/reports
- ☐ List of current medications *(dose, frequency, length of time on current medications)*
- ☐ PT Assessment and Progress Notes
- ☐ OT Assessment and Progress Notes
- ☐ Pre-Admission BADL's
- ☐ Nursing notes of prior 48 hours *(include wound care)*
- ☐ Dietary Assessment Notes
- ☐ Feeding/Swallowing Assessment Notes (VFSS)
- ☐ SLP Assessment Notes
- ☐ Social Work Assessment Notes
- ☐ Home Care Assessment
- ☐ Any follow up appointments *(with whom, date, time, phone/fax number(s) and address)*
- ☐ All completed consultations
- ☐ Completed GDS; Cognitive Assessment or MOCA and/or EXIT

Referred By

Name (print)	Signature
Phone Number	Fax Number

OFFICE USE ONLY

Referral Received *(yyyy-Mon-dd)*

Alberta Health Services

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Specialized Geriatrics Inpatient Intake Referral

Admission Checklist

Purpose: This checklist is to accompany the Glenrose Specialized Geriatrics Inpatient Intake Referral form for all referrals from acute care and the community and is to ensure that the patient is medically stable and appropriate for rehabilitation.

Program Description: Short stay Inpatient Geriatric Rehabilitation program is for individuals who have had an acute change in function and require 2-3 weeks to reach pre-morbid functional level and return to previous living location. The "Regular" Assessment and Rehabilitation program is for medically complex patients requiring a slightly longer rehabilitation time, generally 3-5 weeks and are expected to return to their pre-admission discharge location. The Cognitive Behavioral program is for those patients who have disruptive behaviors or symptoms in addition to being medically complex elderly.

Please answer the following questions	(✓) Yes	(✓) No
Has the patient had an acute change in function and expected to return to their previous level of function? ☐ in 2-3 weeks ☐ in 3-5 weeks		
Is the patient medically stable?		
Does the patient require intermittent IV meds *(no continuous IV)*?		
Does the lab work reflect a stable condition?		
Has relevant diagnostic testing been completed?		
Prior to the patient's current functional/medical changes, was patient independent with mobility?		
Prior to the patient's current functional/medical changes, were the patient's basic ADL's managed *(independent, by family, or by homecare etc.)*?		
Does the patient have significant rehabilitation potential?		
Does the patient demonstrate consistent ability and motivation to participate in active rehab?		
Is the patient able to register, retain and follow through with instruction?		
Are all limbs at least partial weight bearing if affected limb required for ambulation? E.g. walker users require ALL 4 limbs to be partial weight bearing.		
Does the patient have the potential to return to previous community living? ☐ in 2-3 weeks ☐ in 3-5 weeks		
Is the patient expected to be able to return to pre-admission location?		

Signature Required by:

In hospital referring Physician/Nurse Practitioner or Community Specialized Geriatric Team Members*: *(*Specialized teams in the community such as Senior's Clinics, Homecare Geriatric Teams, Integrated Home Supportive Living Teams)*

Print Name	Signature
Phone Number	Date *(yyyy-Mon-dd)*

Process for Admission:

1. Central Intake Nurse is available Monday to Friday, 0800 – 1600h and can be reached at 780.735.8820. Please fax completed Admission Criteria Checklist and Specialized Geriatric Inpatient Intake Referral Form to: 780.735.8821.
2. Forms will be reviewed by Central Intake Nurse for completeness and patient appropriateness for program.
3. Patient will be transferred to first available bed; transfer may be within 24 hours.