Alberta Health Services

# Stroke Early Supported Discharge (ESD) Referral
## North, Central and South Zones

For Clients who meet the following criteria:

- Recent mild to moderate stroke *(within the last 3 months)*
- FIM® score or projected FIM® score *(from AlphaFIM®)* greater than or equal to 70
- Medically stable
- Medical needs that can be supported by Home Care
- Client is willing and able to participate for a minimum of 60 minutes to a maximum of 3 hours a day, 5 days a week
- Cognitively able to participate *(i.e. demonstrates carry over from session to session)*
- Client can safely manage in home environment *(with/without family)* including lodge and supportive living *(excluding Long Term Care and SL4D)*
- Short-term treatment required *(4-8 weeks)*
- At least one discipline required to facilitate early discharge

| Name *(last)* | *(first)* |
|---|---|
| Birthdate *(yyyy-Mon-dd)* | Gender |
| PHN / ULI | |
| City/Town | |
| Phone(s) | |

**Please contact the appropriate Provincial ESD team for further information regarding catchment areas:**

**Grande Prairie**
Phone 780.357.2515
Fax 780.357.2559

**Camrose**
Phone 780.679.3109
Fax 780.679.2847

**Red Deer**
Phone 403.406.5648
Fax 403.406-5561

**Medicine Hat**
Phone 403.502.8648
ext 1297
Fax 403.529.8021

**Lethbridge**
Phone 403.388.6912
Fax 403.388.6096

| **Caregiver/Contact for Patient** | | |
|---|---|---|
| Name | Phone | Alternative Phone *(cell, etc.)* |

**Disciplines Required**

| | | |
|---|---|---|
| ☐ Physiotherapy | ☐ Occupational Therapy | ☐ Speech Language Pathology |
| ☐ Social Work | ☐ Recreation Therapy | ☐ Registered Nurse |

Please Include with Referral (if available)
- ☐ Projected AlphaFIM® or FIM® Score _____
- ☐ Current medication list
- ☐ Rehabilitation notes
- ☐ Depression screen report
- ☐ Physiatrist/Neurologist Report
- ☐ Diagnostic Reports
- ☐ Goals of Care _____

- ☐ Physician aware of ESD referral
- ☐ Physicians involved with care _____

**Referrals made**
- ☐ Home Care
- ☐ Stroke Prevention Clinic
- ☐ Other _____

**Relevant Concerns/Comments**

| | |
|---|---|
| PT | Rec T |
| OT | SW |
| SLP | RN |

**Referral Information**

| Referral Site | | Phone |
|---|---|---|
| Referring Contact Name | Discipline | Signature |

| **Office Use Only** | Date of initial contact with referral source *(yyyy-Mon-dd)* |
|---|---|