Western Cape Government
Health

Referral to Rehabilitation and Intermediate Care Facility

Please complete in legible handwriting

THE COMPLETION OF THIS SECTION IS COMPULSORY

CLIENT'S PERSONAL INFORMATION (Hospital sticker to be used)

First name: _____ Residential address: _____

Surname: _____ _____

_____

Gender: Male ☐ Female ☐

ID No : _____ DOB: _____ AGE: _____

Contact no: _____

Responsible carer or relative: _____Tel_____

Referring health worker: _____ (**Name and Position)**

Referring Hospital / CHC/Clinic/Other: _____ Tel: _____

Hospital / CHC folder no: _____ Date: _____

Dept: _____ E-mail address: _____

Ward: _____

Reason for referral – please tick the most appropriate block(s)

☐ Intense short-term rehabilitation ☐ Palliative Care

☐ Wound care ☐ Convalescent Care

SECTIONS TO BE COMPLETED:

A. **Medical Report: Medical practitioner/ professional nurse must complete this section page 2**
B. **Nursing Care Report: Medical practitioner/professional nurse must complete this section pg 3**
C. **Rehabilitation Report: OT, Physiotherapist & Speech Therapist page 5**
D. **Social Workers Report: Social Worker page 7**

Admission Criteria

- Client must be 18 years and older
- Clients who still require care follow an acute hospital treatment who are not well enough to be discharge home.
- Clients requiring rehabilitation with a fair to good prognosis, following stroke, fracture, joint replacement, amputation, head injury and mental illness.
- Client requiring palliative care where symptom and pain control is required.
- Clients with complex and or chronic wounds that would benefit from reducing or eliminating causative factors and who require systemic and topical support for healing.

Exclusions

- Client who are actively dying
- Client on ventilators
- All medical emergencies
- Clients who are pregnant (SA Nursing regulation 2598 – must be a doctor to manage pregnant women
- Clients arriving for admission outside admission hours as stipulated under requirement by referring entity
- Clients with active TB not yet on therapy (including XDR)
- Highly infectious diseases
- Acute psychotic clients
- Clients on continuous IV Therapy
- Clients still requiring special laboratory investigations (if required by referring institution in preparation for follow-up appointment, then the name of the institution referring Doctor and Department should be filled on the laboratory form so that the lab can send these back to the referring sites)
- Clients with an expected ALOS of more than six weeks requiring long-term specialized , in- patient rehabilitation

A. MEDICAL REPORT:

Functional Report: **THE COMPLETION OF THIS SECTION IS COMPULSORY**
A medical practitioner or professional nurse must complete this section

Date of admission at referring hospital: _____

Date of discharge from referring hospital: _____

Diagnosis including co-morbidities:
_____

_____

_____

Date of onset: _____

Present symptoms:
_____
_____
_____

Prognosis:

Clinical summary: (Including, if possible, copies of RELEVANT investigations and reports)
Please list all investigations done (as this avoids duplication). Please list all surgical interventions and dates.

Special Needs Re: weight bearing and mobilization

Is the client on medication? Yes ☐ No ☐

If yes, please list below:
(On discharge, one month's supply of current medication must accompany the client. Please indicate if medications need to be tapered or discontinued, and if so, when.)

PTB

Sputum: Direct Pos _____ or Neg _____ or Awaiting results _____

Culture: Sensitive_____ or Resistant_____

TB Treatment: Date of commencement_____

HIV Positive: Yes _____ No _____ CD4 count _____ Date _____

B. NURSING CARE REQUIRED:

Client who still requires care, following an acute hospital treatment who is not well enough to be discharge home

Functional Report: **THE COMPLETION OF THIS SECTION IS COMPULSORY**

A medical practitioner or professional nurse must complete this section

Level of consciousness: Assessed and report according to the Glasgow Coma Scale:

Nasogastric tube: Yes ☐ No ☐

Tracheostomy: Yes ☐ No ☐

Bladder control: Continent ☐ Incontinent ☐

Incontinent Catheter: Yes ☐ No ☐

Catheter cared for by: _____

Bowel action: Continent ☐ Incontinent ☐ Constipation ☐

Normal ☐ Diarrhoea ☐

Body weight: Obese ☐ Overweight ☐ Normal ☐ Underweight ☐

Are there periods of confusion? Yes ☐ No ☐

Does the client demonstrate aggressive behaviour? Yes ☐ No ☐

Wound Care

Wounds / Pressure sores present? Yes ☐ No ☐

If yes: Details of Wounds: _____

Pressure sores: _____

Was patient admitted with a pressure sore? _____

If yes, where was patient referred from (where did pressure sore start) _____

Site: _____

Size: _____

Depth: _____

Current Wound care:

- Dressing type: _____

- Application/ ointment etc.:_____

Completed by: _____ Designation: _____

Contact no: _____ Date: _____

FUNCTIONAL REPORT:

THE COMPLETION OF THIS SECTION IS COMPULSORY
Any health worker can complete this section

PHYSICAL ABILITY: Is the patient able to participate in a rehab program? Yes ☐ No ☐

	Totally dependant	Physical/ verbal help	Supervision	Independent
Eating/ Drinking				
Dressing				
Toileting				
Walking				

Wheelchair user? Yes ☐ No ☐

Wheelchair issued: Yes ☐ No ☐

If No is the client placed on a waiting list: Yes ☐ No ☐

	Totally dependant	Physical/ verbal help	Supervision	Independent
Propelling of chair				
Transfer in/ out of chair				

Wheelchair (only if yes above):
Type: _____ Cushion: _____

Ambulation: Assistive device: _____ Max .Distance: _____

Mental Status: Orientated: Yes: ☐ No: ☐

Short – term memory intact? Yes: ☐ No: ☐

Motivation: Poor: ☐ Average: ☐ Good: ☐ Excellent: ☐

Premorbid Functioning: Poor: ☐ Average: ☐ Good: ☐ Excellent: ☐

What rehabilitation plan has been established?

_____

C. REHABILITATION REPORT: An occupational therapist, physiotherapist & Speech Therapist should complete this section

Occupational Therapy Report:

Describe current highest level of function.

Treatment given:

_____
_____
_____

Progress of the client:

_____
_____
_____
_____

For how long was the treatment given and how often?

_____
_____
_____
_____

Compiled by: _____ Designation: _____

Tel No. _____

Email: _____ Date: _____

Physiotherapy Report:

Describe current highest level of function.

Treatment given:

_____
_____
_____

Progress of the client:

_____
_____
_____
_____

For how long was the treatment given and how often?

_____
_____
_____
_____

Compiled by: _____ Designation: _____

Tel No. _____

Email: _____ Date: _____

Speech Therapy Report:

Describe current highest level of function.

Treatment given:

_____
_____
_____

Progress of the client:

_____
_____
_____
_____

For how long was the treatment given and how often?

_____
_____
_____
_____

Compiled by: _____ Designation: _____

Tel No. _____

Email: _____ Date: _____

A. SOCIAL WORKER REPORT:
THE COMPLETION OF THIS SECTION IS COMPULSORY
Social worker or other professional where social worker is not available.

Have the client and carer been informed of the prognosis? Yes ☐ No ☐

Has an application been lodged at any old age home / institution?

Yes ☐ No ☐ N/A ☐

Name of institution: _____ Date lodged: _____

Date approved: _____

Community resources contacted (specify): _____

Future planning regarding discharge: (OAH, Care Facility, HBC, Home (Who would support.)

_____

Information completed by:

Name: _____ Designation: _____

Contact no: _____

E-mail address: _____ Date: _____

Names and addresses of Responsible Relatives / friends / significant others:

Relationship	Name	Address	Telephone no.

FAMILY BACKGROUND

Client lives: Alone With - Name: _____ Relationship:_____

Home Language: _____

Client's marital status:

Married ☐ Divorced ☐ Single ☐ Widowed ☐

Does Spouse work? Yes: ☐ No: ☐

Is the client currently employed? Yes: ☐ No: ☐

Is the client expected to return to work? Yes: ☐ No: ☐

Housing Conditions :

Self Owned ☐ Boarding ☐

No fixed Abode ☐ Rented ☐

Informal Housing ☐ Formal housing ☐

FINANCIAL CIRCUMSTANCES

Monthly income: R0 – R4000 R4001 – R8000 More than R8000

Is client on a state pension/ grant? Yes: ☐ No: ☐ N/A: ☐

Where: _____ When: _____

Is client on a medical aid? Yes: ☐ No: ☐

Name of Medical aid: _____ Membership No. of Medical aid: _____

Does the applicant have a burial policy? Yes: ☐ No: ☐

Name of policy: _____ Value: _____

If this application is unsuccessful, what other alternatives have been considered?_____

_____