Western Cape Government

Referral to Intermediate Care Facility: <u>ADULT PATIENT</u>

Please complete in legible handwriting / typed

CLIENT'S PERSONAL INFORMATION (Hospital sticker to be used)	
Name and Surname	
Date of Birth	
Age	
Gender	Male Female
Contact number	
Responsible relative & relation to patient	
Home language	

REFERRING FACILITY INFORMATION	
Referring Health worker (name and designation)	
Health Worker contact number	
Health Worker Email address	
Referring facility	
Hospital /PHC Folder number	
Department	
Ward	
Responsible relative	

REASON FOR REFERRAL (tick appropriate box)							
Intense Short-Term Rehabilitation		Palliative Care		Wound Care		Convalescent Care	

SECTIONS TO BE COMPLETED:

A. **Medical Report: Medical practitioner/ professional nurse to complete this section**
B. **Nursing Care Report: Medical practitioner/professional nurse to complete this section**
C. **Rehabilitation Report: Attending allied health professionals to complete this section**
D. **Social Workers Report: Social Worker to complete this section**

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

SECTION A: MEDICAL REPORT				
Date of admission to referring facility		Date of discharge from referring facility		
Clinical Summary				
Past medical and surgical history as well as baseline prior to this admission				
Clinical summary of this admission including relevant investigation and results				
GCS	E…..M…..V….. ……/15			
TB	Yes (DS or DR-TB)	No	Awaiting results	
	If yes- patient should be on medication for 2 weeks before consideration for admission			
RVD status	RVD Reactive	RVD Non-Reactive		
	If RVD reactive Is patient: on ART / ART still to be initiated? CD4 count …….. / CD4 not known			
Prognosis	Good	Fair	Poor	Guarded
Weight bearing status for any orthopaedic injuries	Injury	Mx	Weightbearing status	
Medication	Name	Dosage	Frequency	Duration

Attending Dr Name and Surname	Designation	Signature
	Contact number	Date

SECTION B: NURSING REPORT				
Orientation and General Nursing (tick)				
Is patient confused?	Yes		No	
Is patient aggressive?	Yes		No	
Intake	***Feeding route (please tick)***			
	NGT	Oro-gastric tube	PEG	
	Please complete for NGT/peg patients			
	Name of feed:	Continuous / Bolus	Feeding rate:	
Tracheostomy	Yes	No	Trache closed	
Is patient on oxygen?	Yes	No	If yes: Was application done for home oxygen?	
Bladder	Continent		Incontinent	
Bowel	Continent		Incontinent	
Catheter	Yes		No	
	If yes: indwelling / intermittent Managed by (tick): self / nursing staff			
Body weight	Underweight	Normal	Overweight	Obese
Wounds				
Wounds	Patient has surgical wound/s?	Yes	No	
	Patient has pressure sore?			
	Location of wound/s			
	Wound condition			
	Wound size and depth			
	Dressing / ointment used			
	Where did pressure sore originate?	Home	At facility	
Attending Nursing Professional Name and Surname	Designation		Signature	
	Contact number		Date	

SECTION C: FUNCTIONAL REPORT				
Is patient able to participate in a rehab programme?	Yes		No	
Is patient orientated?	Yes		No	
Is short-term memory intact?	Yes		No	
Motivation	Poor	Average	Good	Excellent
Baseline functioning	Poor	Average	Good	Excellent
Current functional ability (tick)				
	Dependent	**Physical / Verbal Help**	**Supervision**	**Independent**
Eating / Drinking				
Dressing				
Communication				
Walking				
Wheelchair mobility				
Assistive Devices (tick)				
	Walking frame	Crutches	Quadropod	Walking stick
	Wheelchair	Splint	AFO	AAC board
	Hearing aid	Visual Aid	Other:	
Was device issued?	Yes		No	
REHABILITATION REPORTS				
Occupational Therapy				
Was patient seen by OT?	Yes *(complete below)*		No / Not indicated	
Describe current level of function				
Progress				
How long was treatment given				
Attending Occupational Therapist Name and Surname	Designation		Signature	
	Contact number		Date	
Physiotherapy report				
Was patient seen by PT?	Yes *(complete below)*		No / Not indicated	
Describe current level of function				
Progress				
How long was treatment given				

Attending Physiotherapist Name and Surname	Designation	Signature
	Contact number	Date
Speech Therapy Report		
Was patient seen by ST?	Yes *(complete below)*	No / Not indicated
Describe current level of function		
Progress		
How long was treatment given		
Attending Speech therapist Name and Surname	Designation	Signature
	Contact number	Date

Dietitian Report		
Was patient seen by DT?	Yes	No / Not indicated
Current intake and feeding requirements		
Progress		
Recommendations		
Attending Dietitian Name and Surname	Designation	Signature
	Contact number	Date

SECTION D: SOCIAL WORK REPORT		
Has patient been informed of the prognosis?	Yes	No (specify reason why not)
Has carer / next of kin been informed of the prognosis	Yes	No (specify reason why not)
Responsible relative / Carer Name and Surname	Address	
	Contact number	
Alternate relative / Carer Name and Surname	Address	
	Contact number	

Family Background (tick)				
Living Situation	Alone	With family	In OAH / shelter	Other
Housing conditions	No fixed abode	Self-owned	Renting	Formal / Informal
Marital status	Married	Divorced	Widowed	Single
Financial Status	Employed	State / Civil Pensioner	Disability Grant	Unemployed
Income	Nil	R0-R4000	R4001-R8000	> R8000
Medical Aid	No	Yes	Details:	
Burial Policy	No	Yes	Details:	
future planning (tick)				
Client support needs	Psychosocial support	Family Education	Mental Health Support	Substance misuse support
Client documentation needs	ID	Other:		
Client financial needs	Pension application	Grant in Aid	Disability Grant	Child support grant
Discharge support	OAH placement	CBS referral	Spiritual support	FAMSA/ Other
Other				
Attending Social Worker Name and Surname	Designation		Signature	
	Contact number		Date	