# Complex Continuing Care Referral

<table>
<thead>
<tr>
<th>Date of Referral to Complex Care: dd/mm/yy</th>
<th>From:</th>
<th>Ext.</th>
</tr>
</thead>
</table>

**Acute Admit Date:** dd/mm/yy

**Admitted from:**
- Home
- Retirement Home
- Nursing Home
- Other

**Family Physician Name:** (print first, last)

**Consults this admission:**

**Admitting DX:**

**Current DX:**

**Medical HX:**

**Surgical HX:**

**CONTRIBUTING COMPLEX FACTORS** (ie. IV medications, IV feeding/enteral, tracheostomy, ventilator, ulcer care: stages 3-4, pressure release devices, complex dressings)

**MRSA:** Date: dd/mm/yy
- Pos
- Neg

**C-Diff:** Date: dd/mm/yy
- Pos
- Neg

**Advanced directives on chart:**
- No
- Yes

**Medical Status:** Patient is medically/surgically stable.
- Yes
- No

Has there been any significant change in the last 3 days?
- Yes
- No

Explain:

Has patient been seen by primary physician in the last 3 days and confirms patient is stable?
- Yes
- No

## PREVIOUS FUNCTIONAL STATUS/HISTORY OF PATIENT

**Mobility:**

**Continence:**

**Cognitive Status:**

**Social situation: Family/Caregiver:**

**Community Support:**

**Patient/Family Goals/Expectations:**

**Recommendations/Comments/Team Plans:**

Reviewed and agreed on by Patient Signature:__________

Reviewed and agreed on by Family Signature:__________ Date: dd/mm/yy
## Complex Continuing Care Referral

### Case conference held:

<table>
<thead>
<tr>
<th>If LTCF indicated, please attach PCS applications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.L.C. date designated: <strong>dd/mm/yyyy</strong></td>
</tr>
</tbody>
</table>

### Other Discharge Plans:

**Primary Contact Person(s):**

1. **Name:** *(print first, last)*  
   **Address:**  
   **Home Phone #:**  
   **Bus. Phone #:**

2. **Name:** *(print first, last)*  
   **Address:**  
   **Home Phone #:**  
   **Bus. Phone #:**

**POWER OF ATTORNEY:**  
**Financial:**  
**Yes**  
**No**  
**Personal:**  
**Yes**  
**No**

**Discipline:**  
**Date:** **dd/mm/yyyy**  
**SW/DP**  
**NURSING**  
**PT**  
**OT**  
**SLP**  
**DIETITIAN**

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*Note: Attach a copy of LTCF application with this referral.*

“Functional Assessment Placement Co-ordination Services” (pink form) is attached even if LTCF application not applicable.

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**BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL**

**Name:** *(print first, last)*  
**Signature:**  
**Date:** **dd/mm/yyyy**  
**Time:** _________

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**FOR COMPLEX MEDICAL REHAB USE ONLY**

**Report received by Name:** *(print first, last)*  
**Date:** **dd/mm/yyyy**  
**Time:** _________

**Report taken by Name:** *(print first, last)*  
**Date:** **dd/mm/yyyy**  
**Time:** _________

**Date referral received:** **dd/mm/yyyy**  
**APPOINTMENT –**  
**Date:** **dd/mm/yyyy**  
**Time:** _________