Covenant Health
St. Michael's

Reset Form

SENIORS' DAY PROGRAMS - REFERRAL FORM

Geriatric Community Rehabilitation, Bridges and the Adult Day Program

PHONE: (403) 388-6940 FAX: (403)388-6949

Intake assessments are done for all referrals to determine which program most suits their needs.
SDP will notify client or designate of intake assessment appointment.

Date:	Referring Physician:	
Family Physician:	Home Care Case Coordinator:	
CLIENT INFORMATION		
Name:	Current Location: □ home □ other_____	
Date of Birth (dd/mon/yyyy):	Age:	Gender: □ Male □ Female
Address:		
City:	Postal Code:	Phone:
AHC #:		
Person to Notify for Appt: □Client directly □Other _____	Relationship: _____	Phone: _____

REASON FOR REFERRAL

Reason for Referral/Current Diagnosis/Recent Hospital Admission(s): □ Post Ortho Surgery □ Post PARP

_____

_____

_____

Medical History: □ CVA or TIA □Parkinson's □Chronic Pain □Hypertension □CAD □PVD □Angina □ Arrhythmia □Cancer □ COPD □ Dialysis □ Diabetes □Osteoarthritis □Falls □Mental Health Diagnosis
Other:_____

_____

Is client willing to attend program? □**Yes** **If not,** consider other community programs for rehabilitation, activity, socialization, mental health or respite (AHS Home Rehabilitation Therapy program, senior's centres, outpatient physiotherapy at CRH, a community physiotherapy provider, AHS Alberta Health Living supervised exercise program, SMHOP, community based seniors exercise, respite arranged by Home Care, community recreation therapy referral by Home Care)

CURRENT FUNCTIONAL STATUS

Can client tolerate 2 hours physical activity a day? □ Yes □ No
Cognition: □ Normal □ Impaired Rudas score if completed:_____/30 Slums score if completed:_____/30
Diagnosis of dementia? □ No □ Yes Type: _____
Behaviors: _____
Elopement risk? □ Yes □ No **Caregiver burden identified?** □ Yes □ No
Transfers: □ Independent □ Needs supervision and/or verbal cues. □ Requires assistance of:___ person(s)
Mobility: □ Walks independently. Aids: □ Single cane □ Quad cane □ 2wheel walker □ 4 wheel walker
□ Walks with the assistance of: _____ person(s) □ Independent mobilizing wheelchair.
History of Falls? □ No □ Yes/Explain_____
Diet: □ Regular □ Cardiac □ Diabetic Other:_____ **Eating :** □ Independent □ Needs assistance
Skin: □ Intact Wound care: _____
Continence of bladder: □ Continent □ Incontinent □ Indwelling catheter/Intermittent catheter
Continence of bowel: □ Continent □ Incontinent □ Ostomy

COMMUNICATION

Primary language:_____ **English fluency**: □ Elementary □ Advanced
Speech/Communication: □ Normal □ Receptive aphasia □ Expressive aphasia □ Dysarthria □ Apraxia
Vision: □ corrected □ uncorrected □ adequate □ deficits _____ _____
Hearing: □ adequate □ hearing aids □ deficits _____

ADVANCED CARE PLANNING

Goals of Care Level: _____ □ None
Personal directive: □ None □ Completed □ Enacted /Guardian_____

EXCLUSION CRITERIA

1. Client deemed medically unstable.
2. Client requires mechanical lift (ie Sabina or Golvo) or is a 2-person heavy transfer.
3. Client has cognitive impairment to such degree that they are unable to follow instructions.
4. Client has disruptive, aggressive or inappropriate behaviour that cannot be managed in the programs.
5. Client resides in a long term care setting. Supportive living residents are permitted to attend GCR program but not Bridges or ADP.
6. Client with acute infectious disease (dermatological, gastrointestinal or respiratory)