Head Injury Rehabilitation Ontario

MEDICAL STATUS FORM - RESIDENTIAL

Tel: 905-523-8852 ext. 123 **Fax:** 905-523-8211
Email: admissions@hiro.ca **Web:** www.hiro.ca

TO BE COMPLETED BY **PHYSICIAN OR NURSE PRACTITIONER**

APPLICANT INFORMATION:

_____ First Name/Last Name

_____/_____/_____ Date of Birth (MM/DD/YYYY)

_____ Height (cm)

_____ Weight (lbs)

_____ Address Street City Postal Code Unit #

_____ Phone Number

Is the applicant's diagnosis an acquired brain injury? ☐ Yes ☐ No
*(If **NO**, this applicant is not eligible for HIRO's services; please discontinue this form)*

If yes, please specify the diagnosis: _____

Please list any other diagnostics relative to function (*e.g. mood disorders, cardiovascular or respiratory disease, metabolic diseases, autoimmune diseases, sleep disorders, neurological or neuromuscular disorders*):

_____

Does this applicant require any regulated nursing duties/controlled acts, including but not limited to: *(select all that apply and attach script(s)/directives)*

☐ Intra-muscular Injections ☐ Subcutaneous injections ☐ Bowel Stimulation ☐ Catheterization

☐ Wound Care ☐ Other: _____

CAPACITY FOR REHABILITATION:

Successful applicants to HIRO's 24 hour residential services must demonstrate some capacity for rehabilitation. Please identify this applicant's abilities int the following areas:

Orientation	☐ Yes – Oriented to person and place ☐ No – Not oriented to person, place, or time ☐ Uncertain
Comprehension	☐ Yes – Follows 1 to 2 step commands ☐ No – Cannot follow 1 to 2 step commands ☐ Uncertain
Memory Deficit	☐ Has working memory deficit (cannot retain basic / simple information >5 minutes) or cannot sustain attention more than 5 minutes ☐ Has short term memory deficit ☐ Has no significant memory deficit ☐ Uncertain
New Learning	☐ Yes – responds to compensatory techniques and/or demonstrates retention of new learning ☐ Potential to learn basic skills using repetition and/or compensatory strategies (e.g. timers, alarms, calendars) ☐ Unable to demonstrate any new learning, even with compensatory strategies ☐ Uncertain
Demonstrates some insight into referral for rehabilitation	☐ Has some insight into physical, cognitive, or behavioural deficits ☐ Admits to physical deficits or restrictions (e.g. hemiparesis, weakness, mobility issues, not allowed to drive or work), but may not recognize cognitive/ behavioural deficits ☐ Has no self-awareness or insight into any deficits ☐ Uncertain

CAPACITY FOR REHABILITATION *continued...*

Goals for rehabilitation	
	☐ Has some realistic life skills goals (e.g. meal preparation, showering, dressing) ☐ Has unrealistic/ambitious goals for recovery (e.g. expectation to regain full function after SCI or hemiparesis, independent living, return to work or driving) ☐ Requires exploration for non-pharmaceutical or non-physical restraint options for managing behaviours to improve quality of life ☐ No rehabilitation goals

MEDICAL HISTORY:

In considering this applicant's ***recent medical history*** *(i.e. within 7 years)*, please rank the frequency, intensity and stability of their condition(s), if applicable:

LEGEND			
FREQUENCY	Low: monthly or less	Moderate: weekly	High: > weekly
INTENSITY	Low: may require up to 15 minutes from an unregulated staff to manage; never requires EMS intervention	Moderate: may require up to 30 minutes from an unregulated staff to manage; may require EMS intervention	High: may require up to 1 hour from an unregulated staff to manage; likely requires EMS intervention
STABILITY	Low: Co-morbidities have been stable for > 1 year	Moderate: Co-morbidities fluctuate, but support is present *(e.g. medicine trials, partnerships, AA)*	High: Co-morbidities require further investigation

	FREQUENCY	INTENSITY	STABILITY	COMMENTS
Seizures	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Panic Attacks	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Self Harm	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Choking	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Falls	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Diabetes	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	

MEDICAL HISTORY *continued...*

	FREQUENCY	INTENSITY	STABILITY	COMMENTS
Urinary Tract Infection	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Chronic Pain	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	☐ N/A ☐ Low ☐ Moderate ☐ High	
Communicable Diseases *(TB, HIV, MRSA, Hepatitis)*	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

ATTESTATION

☐ I, confirm that this Applicant is suitable to reside in a 24-hour care facility with no regulated staff, no nursing services, and no seclusion rooms (isolated confinement). All client emergencies are escalated to 911/emergency services.

☐ I, confirm this Applicant is not being queried for/diagnosed with a progressive or degenerative disease/disorder (e.g. dementia, malignant tumor/cancer etc.).

☐ I, confirm the Applicant is not diagnosed with an in-utero/at birth ABI, pediatric (<16) ABI, or developmental disability that severely impacted reaching developmental milestones in youth. *If the brain injury occurred under age 16, please consider a referral for Developmental Services Ontario.*

☐ I, confirm that this Applicant is medically cleared for the use of basic Crisis Intervention and Prevention techniques including physical holds, blocks, and escorts when necessary to safely manage imminent risk of harm.

Date completed: _____
(DD/MM/YYYY)

I, _____
PRINT First Name/ Last Name/ Profession/ Designation

Certify that the above information is complete and accurate to the best of my knowledge at the time of application.

_____
Signature

Physician/Nurse Practitioner Contact information:

Address: _____

_____

_____

Telephone: _____

CPSO #/ Registration #:_____

What is your relationship to this applicant?

☐ Family Physician

☐ Walk-In Physician

☐ Specialist/Consultant

☐ Other: _____

Please ensure the following are attached, if applicable:

❑ Current medication list
❑ Script(s)/directives for controlled acts
❑ COVID vaccination history

Please **return** completed form to:

Head Injury Rehabilitation Ontario
Attn: Admissions Department
508 – 225 King William St.
Hamilton, ON L8R 1B1

Fax: 905 523-8211

Personal health information will be protected by HIRO as per the Personal Health Information Protection Act (PHIPA).

A Promise of Hope After ABI