Peterborough Regional Health Centre
STROKE/REHAB UNIT

INTAKE SCREENING FOR REHAB

Diagnosis:

Onset:
Surgery:

Date of admit: d/ _____ m/ _____ y/ _____

Current Clinical Status	**Findings**
	Co-morbidities:

Infection Control Status: ☐ MRSA ☐ VRE ☐ C Difficile Other: _____

Functional /ADL

Feed: ☐ Independent ☐ Set up
☐ Mod Assist ☐ Total
Wash: ☐ Independent ☐ Set up
☐ Mod Assist ☐ Total
Dress: ☐ Independent ☐ Set up
☐ Mod Assist ☐ Total
Continence: Bladder: ☐ Yes ☐ No Catheter?
Bowel: ☐ Yes ☐ No
Transfers: ☐ Independent ☐ 1 person
☐ 2 person ☐ Total

Activity Tolerance / Endurance:
☐ < 1 hour/day ☐ 1-2 hours /day
☐ 2-3 hours/day ☐ 3 hours/day

Functional Mobility: ☐ Walker ☐ Rollator
☐ Cane ☐ Wheelchair ☐ N/A
☐ Independent ☐ Supervision ☐ Assist
Weight bearing status:

Skin Integrity: Skin Intact ☐ Yes ☐ No
If no, describe:

Nutrition & Hydration:
Type of Diet & Texture:
☐ Dysphagia Enteral Tube ☐ Yes ☐ No

Cognitive Status

Confused	☐ Yes	☐ No
Impaired Memory	☐ Yes	☐ No
Wanderer	☐ Yes	☐ No
Restrained	☐ Yes	☐ No
Recent Falls	☐ Yes	☐ No
Disruptive at night	☐ Yes	☐ No

Social Interaction

Appropriate	☐ Yes	☐ No
Aggressive Behaviour	☐ Yes	☐ No
Withdrawn	☐ Yes	☐ No

Communication

Comprehension Functional	☐ Yes	☐ No
Expression Functional	☐ Yes	☐ No

Language Spoken: _____

Mental Status: MMSE Score: _____
OR CCT results:
Learning:

Able to follow 3 step command	☐ Yes	☐ No
Carry over day to day	☐ Yes	☐ No

Depressive Symptoms: ☐ Yes ☐ No
Describe:

Motivated?: ☐ Yes ☐ No

Comments:

Home set-up screen completed?
Barriers to Discharge:

GOALS: **Patient Goals**

_____

Family Goals

_____

Date of Consultation / Assessment: _____

Recommendation for Service Setting: ☐ Short Term Rehab ☐ Medium Term Rehab
☐ Long Term Rehab _____ ☐ Ambulatory Care (Specify Service): _____ ☐ CCAC

Date Ready for Rehab: _____ **Date Admitted to Rehab:** _____

Signature and Status of Assessor: _____ Date (d/m/y): _____