Alberta Health Services | Covenant Health

Direct Referral
Subacute – Orthopaedics

☐ **TOTAL HIP/KNEE ARTHROPLASTY**
☐ **FRACTURED HIP PROGRAM**

Patient.
Addressograph

FAX TO GRANDVIEW: 780-434-1333

Date: _____ **Acute Care Site:** _____

Unit: _____ **Phone:** _____

Check off all ☐ A copy of each MUST be included with the referral

☐ Demographics ☐ Current Medication Profile ☐ Consults

☐ Best Possible Medical History (BPMH) ☐ PT/OT Notes

Check off all applicable ☐ to indicate which of the following are included with the referral:

☐ Hip & Knee Replacement Surgical Assessment and History–(4 to 5 pages)
☐ Hip & Knee Replacement Living Arrangement/ADL (2 pages)
☐ Hip & Knee Patient Pre-Op Function Status – knee (1 page)
☐ Hip & Knee Replacement Surgical Patient Agreement (3 pages)
☐ Fracture Hip Patient Admission Data Base 1&2
☐ Fracture Hip Patient Information Signed
☐ Anticoagulants Record
☐ Diabetic Record
☐ Insulin orders

Medical/Surgical Information

Surgical Procedure and DATE: _____

Allergies: _____

Medical/Surgical History:

1. Previous Ortho surgery ☐ Yes ☐ No (Comments): _____
2. Other previous surgery e.g. CABG: _____
3. Medical conditions: ☐ Hypertension ☐ Diabetes ☐ CVA/TIA's ☐ Dementia: ☐ Other: _____
   (Comment)_____
4. Risk for TB infection (Refer to Guidelines)
   - TB History: ☐ Yes ☐ No ☐ Unknown
   - Symptoms present: ☐ Yes ☐ No
   - Recent abnormal chest x-ray: ☐ Yes ☐ No
   - Comment:_____

Current Status	1 person assist	2 person assist
Bed Mobility		
Transfers: Chair / Toilet		
WB Status: _____		
	Yes	**No**
*Urinary Management (incontinence)		
*Bowel Management/ostomy (incontinence)		
Last BM Date: _____		

PREINJURY MOBILITY STATUS (Fractured Hip Only)

1. The patient was able to mobilize:
   ☐ without assistance ☐ with assistance
2. Approximate Distance: _____meters

Cognitively able to participate in Rehab Program: ☐ Yes
(Comments* i.e. MMSE, MOCA, etc):
_____
_____
_____

Therapeutic Interventions	Yes	No	Therapeutic Interventions	Yes	No
*Oxygen			*Cast/Splint/Brace Care		
*I.V.s			CPM		
*Wound Care			Special Equipment Needs *eg. Gutter Walker		
Chemstrips					

***Additional Information** which would assist subacute (includes cognitive status, therapeutic interventions):

_____

_____

Information Completed by Charge Nurse / RN Name: _____

Guidelines- Direct Referral Subacute/PostAcute- Orthopaedics

RN -please print name

Checklist - include **all** information that applies to the patient- ie OR Report(if not avail send intraoperative report), if Nursing data base not available, write diet, glasses, etc in Additional info section....

Med/Surg Info - Current Injury/Surgical procedure and date.

Allergies - list all medication, food and environmental allergies/sensitivities - not intolerances.

Med/Surg HX - include pertinent medical history (Cardiac, Respiratory, Orthopaedic, gen surgery...)

Medical Conditions - list the co-morbidities and any pertinent information to current status

Please review and confirm if applies to the patient.
TB Screening include:

Risk for TB Infection:

- Previous TB
- Born in or travel to a TB endemic country
  (e.g. Vietnam, Phillipines, China, Hong Kong, India, Latin America)
- Aboriginal
- Worked as a health care professional
- Previous significant Tuberculin Skin Test (TST/Mantoux)
- Recent contract with TB Infection (2 years)

Symptom Inquiry:

- Persistent cough (3 weeks, especially productive)
- Fever
- Night sweats
- Hemoptysis/blood in sputum
- Unexplained Weight loss

Abnormal chest radiography related to TB (review x-ray report for any of the following descriptors):

- Suspicion of current active TB disease (e.g. upper lung zone pneumonic process, particularly if cavitating or if associated with the acinar shadows of endobronchial spread),
- upper lobe fibronodular abnormality,
- old granulomatous disease or old tuberculosis (does not include single, isolated granuloma),
- thoracoplasty,
- intrathoracic adenopathy with or without a lung parenchymal abnormality in an immune compromised person.

Cognitive – current status, if cognitive issues i.e. dementia history, please clarify and describe as relates to current functioning, ability to follow direction and participate in programing. Please include any testing that has been done and date i.e. MMSE/MoCA. Also if is on the delirium protocol.

Mobility Status – current patient status as of that day.

Please add the following in the additional information section at bottom of referral.

Therapeutic Interventions/Treatment Modalities - comment on all that applies, esp: oxygen, PICC line (type/site/date dressing change), wound drainage, urine/bowel incontinent, foley (date last changed/type/size), date of last bowel movement, alternate consistency diet (need SLP assessment), splints/braces/casts, Chemstrip frequency, special equipment i.e. bariatric include weight and height and girth off-service. Follow up appts.