Western Cape Government
Health

Referral to Paediatric Rehabilitation and Intermediate Care Facility

Please complete in legible handwriting or type into the form.

THE COMPLETION OF THIS SECTION IS COMPULSORY

CHILD'S PERSONAL INFORMATION Folder Number:_____

First name: _____ Residential address: _____

Surname: _____ _____

_____

Gender: Male ☐ Female ☐ DOB: / / AGE:

ID No : _____ Primary Caregiver:_____

Relationship to child: _____Telephone: Home _____Cell_____

Consent given to admission to Intermediate Care Facility: Signed_____Date: / /

Referring health worker: _____ (**Name and Position)**

Referring Hospital / CHC/Clinic/Other: _____ Tel: _____

Hospital / CHC folder no: _____ Date: _____

Dept: _____ E-mail address: _____

Ward: _____

Road to health Booklet: Yes ☐ No ☐

Reason for referral – please tick the most appropriate block(s)

☐ Restorative and rehabilitation Care ☐ Palliative Care ☐ Post-Acute care

☐ Wound care ☐ Convalescent Care ☐ End of Life care ☐ Respite care

Will the parent/care giver be staying with the child?

☐ Yes ☐ No

SECTIONS TO BE COMPLETED:

A. **Medical Report: Medical practitioner must complete this section page 2**
B. **Dietician Report: Dietician must complete this section page 4**
C. **Nursing Care Report: Professional nurse must complete this section pg 4**
D. **Rehabilitation Report: OT, Physiotherapist & Speech Therapist must complete this section page 6 &7**
E. **Social Workers Report: Social Worker must complete this section page 8**

Admission Criteria

- Patient must be 17 years and 11 months and younger
- Patients who still require care follow an episode of acute hospital treatment who are not well enough to be discharged home.
- Patients requiring rehabilitation with a fair to good prognosis.
- Patient requiring palliative care where symptom and pain control is required.
- Patients with complex and or chronic wounds that would benefit from reducing or eliminating causative factors and who require systemic and topical support for healing.
- Patients who need respite care

Exclusions

- Patients who are clinically unstable
- Patients who need more than 40% Oxygen
- All medical emergencies
- Patients who are pregnant (SA Nursing regulation 2598 – must be a doctor to manage pregnant women
- Patients arriving for admission outside admission hours as stipulated under requirement by referring entity
- Patients with active TB not yet on therapy (including XDR)
- Highly infectious diseases
- Acute psychotic patients
- Patients on continuous IV Therapy
- Patients still requiring special laboratory investigations (if required by referring institution in preparation for follow-up appointment, then the name of the institution referring Doctor and Department should be filled on the laboratory form so that the lab can send these back to the referring sites)
- Patients with an expected ALOS (Length of Stay) of more than six weeks requiring long-term specialised , in- patient rehabilitation

A. MEDICAL REPORT:

Functional Report: **THE COMPLETION OF THIS SECTION IS COMPULSORY**
A medical practitioner must complete this section

Date of admission at referring hospital: _____

Date of discharge from referring hospital: _____

Diagnosis including co-morbidities:

_____

_____

_____

Date of onset: _____

Present symptoms and main Problems

_____
_____
_____
_____
_____
_____

Prognosis: (including Resuscitation Status and Intervention level)

_____

Clinical summary: (Including, if possible, copies of RELEVANT investigations, summaries and reports)
Please list all investigations done (as this avoids duplication). Please list all surgical interventions and dates.

_____
_____
_____
_____

On-going care needed

_____

Is the client on medication? Yes ☐ No ☐

If yes, please list below:
(On discharge, one month's supply of current medication must accompany the patient. Please indicate if medications need to be tapered or discontinued, and if so, when.)

_____
_____
_____

Patient has TB: ☐ Yes ☐ No

Duration of treatment:
Who was TB contact:
Is contact on treatment/ prophylaxis: ☐ Yes ☐ No

HIV Positive: ☐ Yes ☐ No

If yes, is patient on ARVs? ☐ Yes ☐ No (If yes, please specify under medication above)

Has patient been given Vitamin A and dewormed recently? ☐ Yes ☐ No Date:_____

Are the patient's immunisations up to date? Yes ☐ No ☐

Doctor's name:_____ **Contact number:**_____

E-mail address:_____

B. DIETICIAN'S REPORT:
A Dietician must complete this section

Anthropometry: Height/Length:_____cm Body weight:_____ Admission weight:_____
BMI: _____ Head Circumference: _____cm

Interpretation of Anthropometry: _____% WFA _____% HFA _____ % WFH
Recent Weight loss/ Gain: _____

NUTRITION PRESCRIPTION: Total kCal____/kg Protein_____(g)_____(g/kg)_____%
Lipid_____(g)_____% Carbohydrate _____(g) _____%

Nutrition Support to be implemented:
_____
_____
_____

Plan of Treatment:
_____
_____
_____

Compiled by: _____ **Designation:** _____

Tel No. _____

Email: _____ **Date:** _____

C. NURSING CARE REQUIRED:
A professional nurse must complete this section

Is the child on Oxygen? ☐ Yes ☐ No

If yes, has an application been made for home oxygen? ☐ Yes ☐ No

Nasogastric tube/ PEG : ☐ Yes ☐ No

Does child have a catheter? ☐ Yes ☐ No If yes, is it Indwelling ☐ Intermittent ☐

Does child have a colostomy? ☐ Yes ☐ No

When was last bowel action?_____

Body weight: ☐ Normal ☐ Moderate Malnutrition ☐ Severe Malnutrition

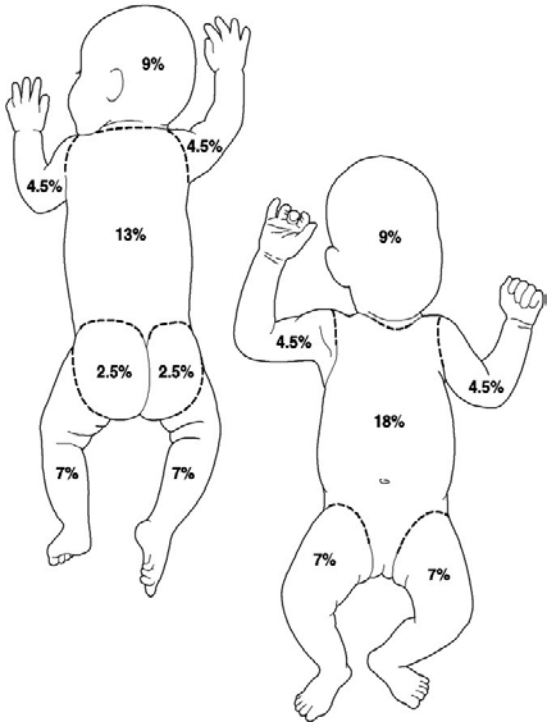
Are there periods of confusion? ☐ Yes ☐ No

Does the child demonstrate behavioural problems:
If so, specify problems and vulnerabilities:

Wound Care

Wounds / Burns /Pressure sores present? ☐ Yes ☐ No

If yes, details of wounds_____



Was patient admitted with a pressure sore? _____

If yes, where was patient referred from (where did pressure sore start)
_____

Site: _____

Size: _____

Depth: _____

Does client have dental caries? Yes ☐ No ☐

<u>Current Wound care:</u>

- Dressing type: _____

- Application/ ointment etc.:_____
-Cleaning Solution:_____

Completed by: _____ **Designation:** _____

Contact no: _____ **Date:** _____

E-mail address:_____

D. REHABILITATION REPORT:
An occupational therapist, physiotherapist & Speech Therapist must complete this section

Does this patient need rehabilitation? Yes ☐ No ☐

Wheelchair/Buggy user? Yes ☐ No ☐

Wheelchair/ Buggy issued: Yes ☐ No ☐

If No is the patient placed on a waiting list: Yes ☐ No ☐

Wheelchair (only if yes above):
Type: _____ Cushion: _____

Ambulation: Assistive device: _____

Premorbid Functioning: Poor: ☐ Average: ☐ Good: ☐ Excellent: ☐

What rehabilitation plan has been established?

Occupational Therapy Report:

Describe current highest level of function.

Treatment given:
_____
_____
_____

Progress of the patient:
_____
_____
_____
_____

For how long was the treatment given and how often?
_____
_____
_____
_____

Is ongoing treatment required? ☐ Yes ☐ No

Follow up appointment for OT:_____

Compiled by: _____ **Designation:** _____

Tel No. _____

Email: _____ **Date:** _____

Physiotherapy Report:

Describe current highest level of function.

Treatment given:

_____
_____
_____

Progress of the patient:

_____
_____
_____
_____

For how long was the treatment given and how often?

_____
_____
_____
_____

Is ongoing treatment required? ☐ Yes ☐ No

Follow up appointment for PT: _____

Compiled by: _____ **Designation:** _____

Tel No. _____

Email: _____ **Date:** _____

Speech Therapy Report:

Describe current highest level of function.

Treatment given:

_____
_____
_____

Progress of the patient:

_____
_____
_____
_____

For how long was the treatment given and how often?

_____
_____
_____
_____

Is ongoing treatment required? ☐ Yes ☐ No

Follow up appointment for ST: _____

Compiled by: _____ **Designation:** _____

Tel No. _____

Email: _____ **Date:** _____

E. SOCIAL WORKER REPORT:
THE COMPLETION OF THIS SECTION IS COMPULSORY
A Social worker must complete this section

Have the patient and carer been informed of the prognosis? Yes ☐ No ☐

Has an application been lodged at an institution?

Yes ☐ No ☐ N/A ☐

Name of institution: _____ Date lodged: _____

Date approved: _____

Community resources/ social worker contacted (specify):

_____

Has a written referral been done? Yes ☐ No ☐

Future planning regarding discharge: (Care Facility, HBC, Home - Who would support.)

_____

Names and addresses of Responsible Relatives / friends / significant others:

Relationship	Name	Address	Telephone no.

FAMILY BACKGROUND

Patient lives with: Name: _____

Relationship:_____ Home Language: _____

Does father/Mother/care giver work? Yes: ☐ No: ☐

Is the patient currently at school? Yes: ☐ No: ☐ Grade: _____

Are there social issues/concerns in the household? Yes ☐ No ☐

What support systems are in place?

Please supply a genogram of family and support.

Housing Conditions :

Self Owned ☐ Boarding ☐ Water ☐

No fixed Abode ☐ Rented ☐ Sanitation ☐

Informal Housing ☐ Formal housing ☐ Electricity ☐

FINANCIAL CIRCUMSTANCES

Monthly income: ☐ R0 – R4000 ☐ R4001 – R8000 ☐ More than R8000

Is patient on a state grant?

☐ Foster Care Grant

☐ Care Dependency Grant

☐ Child support Grant

☐ Applied for Care Dependency Grant

Where: _____ When: _____

☐ Applied for Child Care Support Grant

Where: _____ When: _____

Is patient on a Medical aid? Yes ☐ No ☐

Name of Medical aid: _____ Membership. of Medical aid: _____

SCHOOLING

Does the child attend school? Yes ☐ No ☐

When did child last attend school? _____

Name of school_____

Name of principal_____ Contact number_____

If this application is unsuccessful, what other alternatives have been considered?

_____

Information completed by:

Name: _____ **Designation:** _____

Contact no: _____

E-mail address: _____ **Date:** _____