Western Cape Government
Health

Referral to Paediatric Rehabilitation and Intermediate Care Facility

Please complete in legible handwriting

THE COMPLETION OF THIS SECTION IS COMPULSORY

CLIENT'S PERSONAL INFORMATION Folder Number:_____

First name: _____ Residential address: _____

Surname: _____ _____

_____

Gender: Male ☐ Female ☐

ID No : _____ DOB: AGE:

Primary Care Giver:_____

Relationship to child: _____Tel_____

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

If child needs palliative 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

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

Exclusions

- Clients who are clinically unstable
- Clients who need more than 40% Oxygen
- All medical emergencies
- Clients who are pregnant (SA Nursing regulation 2598 – must be a doctor to manage pregnant women
- Clients arriving for admission outside admission hours as stipulated under requirement by referring entity
- Clients with active TB not yet on therapy (including XDR)
- Highly infectious diseases
- Acute psychotic clients
- Clients on continuous IV Therapy
- Clients 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)
- Clients with an expected ALOS (Length of Stay) of more than six weeks requiring long-term specialized , 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 client. Please indicate if medications need to be tapered or discontinued, and if so, when.)

_____
_____
_____

Client 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 immunizations up to date?

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

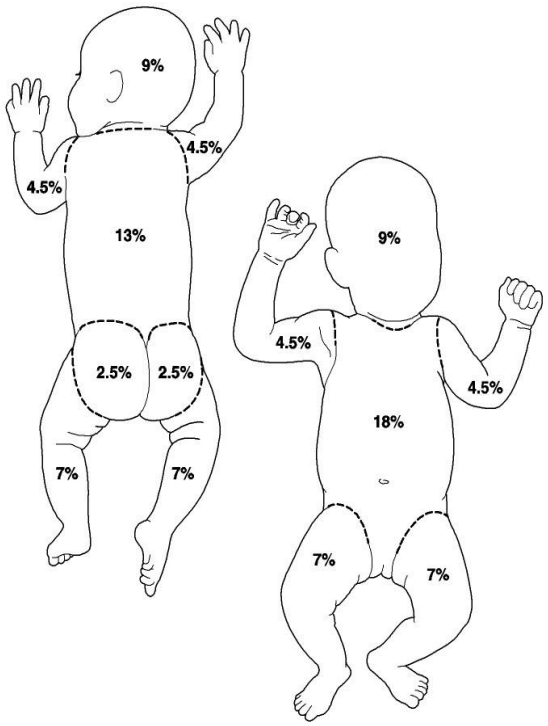
Does the child demonstrate behavioural problems:

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 ☐

Current Wound care:

- 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

PHYSICAL ABILITY: Is the patient able to participate in a rehab program? **Yes** ☐ **No** ☐

	Totally dependent	**Physical/verbal help**	**Supervision**	**Independent**
Eating/ Drinking				
Dressing				
Toileting				
Walking				

Wheelchair/Buggy user? Yes ☐ No ☐

Wheelchair/ Buggy issued: Yes ☐ No ☐

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

	Totally dependent	**Physical/verbal help**	**Supervision**	**Independent**
Propelling of chair				
Transfer in/out of chair				

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

Ambulation: Assistive device: _____ Max distance_____

Mental status: Orientated: Yes: ☐ No: ☐

Short Term memory intact? Yes: ☐ No ☐

Motivation: Poor: ☐ Average: ☐ Good: ☐ Excellent: ☐

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 client:

_____
_____
_____
_____

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 client:

_____
_____
_____
_____

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 client:

_____
_____
_____
_____

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 client 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?

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

Client lives with: Name: _____ Relationship:_____

Home Language: _____

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

Is the client 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 client 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 client on a medical aid? Yes ☐ No ☐

Name of Medical aid: _____ Membership No. 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:** _____