Children's Mercy HOSPITALS & CLINICS Kansas City

Pediatric Rehabilitation Medicine Department
Inpatient Referral Form
(Please complete and fax to 816-855-1934)

Today's Date:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Preferred Name/Nickname:

Birth date:	Age:	Sex: ☐ M ☐ F	Is patient in state custody? ☐ Yes ☐ No

Languages spoken/understood by patient: ☐ English ☐ Spanish ☐ Other, please list	Is an interpreter required for patient? ☐ Yes ☐ No
Languages spoken/understood by parent: ☐ English ☐ Spanish ☐ Other, please list	Is an interpreter required for parent? ☐ Yes ☐ No

PARENT OR LEGAL GUARDIAN INFORMATION (☐ SEE ATTACHED)

Mother's Name:	Home phone no.: ( )	Cell phone no.: ( )	Work phone no.: ( )
Street address:	City:	State:	Zip Code:
Father's Name:	Home phone no.: ( )	Cell phone no.: ( )	Work phone no.: ( )
Street address:	City:	State:	Zip Code:
Legal Guardian Name:	Home phone no.: ( )	Cell phone no.: ( )	Work phone no.: ( )
Street address:	City:	State:	Zip Code:

IS PATIENT IN ISOLATION? ☐ YES ☐ NO IF YES, WHY?

HEALTH HISTORY

☐ **H&P ATTACHED**	☐ **FACESHEET ATTACHED**
☐ **MAR ATTACHED**	☐ **REHAB CONSULT ATTACHED**
☐ **THERAPY NOTES ATTACHED**	☐ **SOCIAL WORK NOTES ATTACHED**

Reason for Referral: ☐ Spinal Cord Injury ☐ Brain Injury ☐ Stroke ☐ Neuro-Oncology

☐ Multiple Trauma ☐ Generalized De-conditioning ☐ Other If other, please explain:

Date of onset:

Pre-existing conditions:

Medications: (oral, feeding tube, topical, inhalation, etc) State medication, times and methods of administration, dose and any other helpful information:

☐ See Attached

Allergies: (drug, food i.e. peanuts, latex, etc.): ☐ See Attached

Active medical issues (e.g., infection, respiratory support, DVT etc.)

PT / OT / ST notes: ☐ See Attached
Therapy evaluations complete: ☐ Yes ☐ Pending
Weight bearing status: ☐ As tolerated ☐ Non weight-bearing (please explain):
Spine restrictions ☐ Yes ☐ No If Yes, please explain:
Cervical Spine: ☐ Cleared ☐ Not Cleared
Activity restrictions: ☐ None ☐ Other (please explain)
Recent Lab Reports (blood, x-ray, i.e. MRI, CT Scan) : ☐ None ☐ See Attached
Special Psychosocial Issues : ☐ None ☐ Other (explain)
Restricted Visitors : ☐ Yes ☐ No If Yes, please explain:
In what state will the patient reside upon discharge? ☐ Missouri ☐ Kansas ☐ Other:
Who is the anticipated caregiver after discharge:
CURRENT FUNCTIONAL STATUS:
Mental Status: ☐ Normal ☐ Confused ☐ Agitated ☐ Minimally Conscious ☐ Coma
Current GCS: Current Rancho:
Mobility: ☐ Independent ☐ Walks w/Assistance ☐ Non-Ambulatory ☐ Non Weight-Bearing ☐ Age Appropriate
Transfers: ☐ Independent ☐ One Person Assist ☐ Two Person Assist ☐ Hoyer
Safety: ☐ Physical Restraints ☐ Helmet ☐ One to One Attendant ☐ Other (please explain)
ADL's: ☐ Independent ☐ Minimally Impaired ☐ Severely Impaired ☐ Age Appropriate
Communication: ☐ Independent ☐ Minimally Impaired ☐ Severely Impaired ☐ Age Appropriate
Diet: ☐ Regular ☐ Dysphagia ☐ Tube Feeds ☐ NPO
Skin: ☐ Pressure Ulcers ☐ Surgical Incisions ☐ Wound Care ☐ Dressing Changes Comments:
Elimination / Bowel: ☐ Continent ☐ Incontinent Comments:
Elimination / Bladder: ☐ Continent ☐ Incontinent ☐ Cath Program ☐ Other (explain)
Vision: ☐ Adequate ☐ Impaired ☐ Blind
Hearing: ☐ Adequate ☐ Impaired ☐ Deaf
Medical Other: ☐ Oxygen ☐ Ventilator ☐ Tracheostomy ☐ BiPAP ☐ CPAP ☐ Dialysis ☐ Bariatric
Central Venous Line : ☐ Yes ☐ No If answer Yes, please explain:

Referring attending name:	Referring attending contact number: ( )
PCP name:	PCP contact number: ( )
Printed name of person completing form:	Date:
Referring Source:	Date: