Rehabilitative Care Alliance

Referral Decision Tree for Rehabilitative Care – To be used with the Rehabilitative Care Alliance Definitions Framework for Rehabilitative Care

***STEP 1:* Determine eligibility for rehabilitative care**

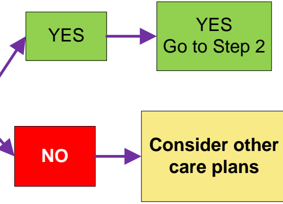
Does the patient/client have restorative potential? That is,

- Is the patient/client medically stable enough to participate in and benefit from rehabilitative care within the context of his/her specific functional goals and environment?
- Does the patient/client have identified goals that are specific, measurable, realistic and timely?

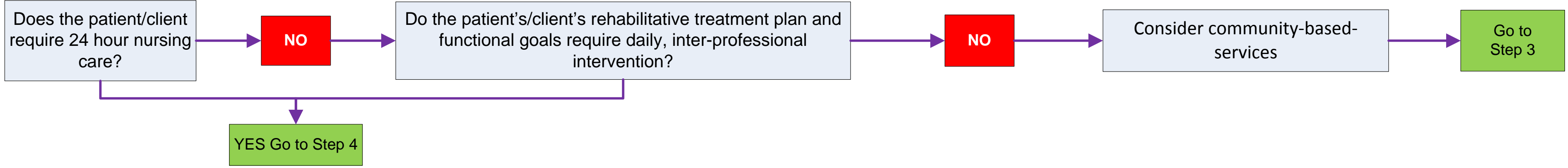
Note: The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:

- o Premorbid level of functioning
- o Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)

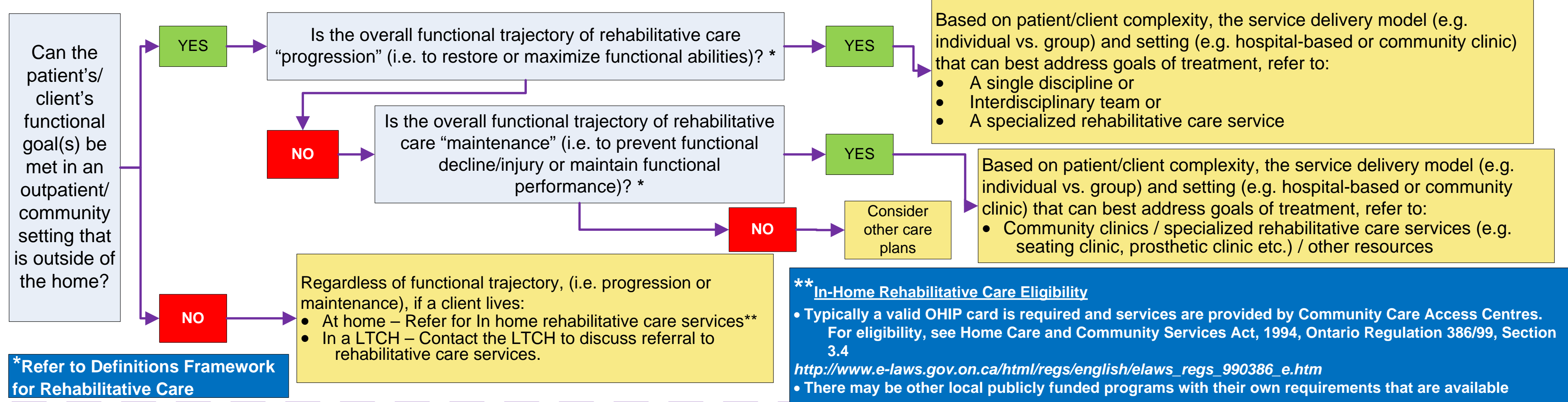
Determination of whether a patient/client has restorative potential includes consideration of all of the above factors. Cognitive impairment, depression, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.



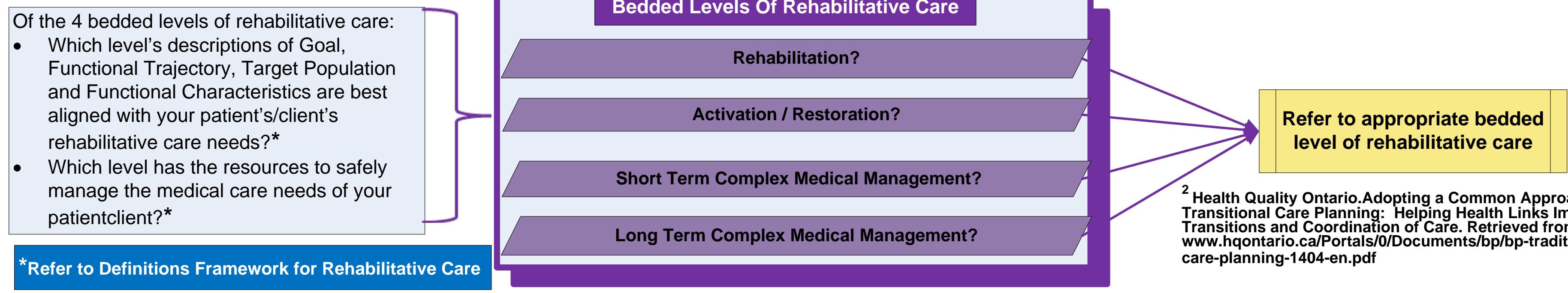
***STEP 2:* Determine if patient's needs can be met by community-based rehabilitative care**



***STEP 3:* Determine overall functional trajectory/goal and setting/ location of community based rehabilitative care**



***STEP 4:* Determine which bedded level of rehabilitative care would meet the needs of your patient**



At each transition point, mechanisms for the coordination and communication of the post-discharge rehabilitative care plan with the receiving provider(s) and patient and families/caregivers should be in place to support a successful transition.[2]

[2] Health Quality Ontario.Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care. Retrieved from http://www.hqontario.ca/Portals/0/Documents/bp/bp-traditional-care-planning-1404-en.pdf