Community Stroke Rehabilitation Team

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Clinical Leader: ____________________

CLIENT INFORMATION

Name:	DOB (YY/MM/DD):
Address:	
Email:	Phone#:
Date of Referral:	Date of First Contact:

INITIAL INTERVIEW DETAILS

Present at Initial Interview: **PT** □ **OT**□ **SLP** □ **SW** □ **RN** □ **TRS**□ **Rehab Therapist** □

Date: ________________________

□ Consent Sheet Signed
□ Contact Sheet Completed
□ ID Checked
□ Confidentiality Discussed
□ Communication Binder Presented
□ Auditory Comprehension Screen Complete

SUMMARY OF ASSESSMENTS ADMINISTERED

Assessment	Initial (Please include date of completion)	Discharge (Please include date of completion)	Follow Up (Please include date of completion)	
Stroke Impact Scale				*6 month follow up*
FIM				*3 month follow up*
PHQ-2 & PHQ-9				*6 month follow up*
Bakas Caregiver Scale				*6 month follow up*

CURRENT GOALS

(In your own words)

RECOMMENDED DISCIPLINE INVOLVEMENT

PT □ **OT**□ **SLP** □ **SW** □ **RN** □ **TRS** □ **Rehab Therapist** □

Date of Next Appointment: ________________________ **, with** ____________________________
(mm/dd/yy)

MEDICAL HISTORY

Can you describe what has happened? (History of Stroke)

Aphasic?: Yes □ No□ If Yes please specify:

Pre-existing/Co-morbid Injuries/Illness?

Medications: (*Can you tell me what medication you take? Do you require assistance?)*

Past Therapies Received:

Have you noticed a change in your vision? Yes □ No□

CURRENT COMMUNITY STATUS

Family members/support:____

____

CCAC *(please include Case Manager name and contact information)* □

Services currently involved (please fill out contact sheet):

PT □ OT□ SLP □ SW □ RN □

Is there a PSW involved with your care? Yes □ No□

If yes please indicate how many hours per week and which days?

Other person/agencies:

Current place of residence:

House □ Apartment □ Retirement Home □ Nursing Home □ Other □

CURRENT HEALTH/FUNCTIONAL STATUS

<u>Physiotherapy</u>

Current mobility: Independent: □ Assist □ Non-ambulatory □

Please specify as required:

Have you fallen in the past 6 months?

<u>Therapeutic Recreation</u>

Leisure Interests:

Prompting question: *What are some activities that you have participated in or are currently participating in that you love to do?*

Leisure Difficulties or Barriers:

Prompting question: *Is there something that you enjoy but feel that you are unable to do?*

Are there times in your day that you feel you need things to do?

How important is it for you to work towards returning to these experiences?

□ Not Important □Somewhat important □Very Important

Speech and Language

Do you have any problems swallowing food or drink? **Yes** □ **No**□

Have you had any recent pneumonias or chest infections? **Yes** □ **No**□

Have you changed how you eat in any way ? **Yes** □ **No**□

Do you have any problems with:

Hearing **Yes** □ **No**□ **Understanding others** **Yes** □ **No**□

Speaking **Yes** □ **No**□ **Having others understand you** **Yes** □ **No**□

Reading **Yes** □ **No**□ **Writing** **Yes** □ **No**□

Do you have any problems with:

Saying what you want to say, when you would like to say it **Yes** □ **No**□

Participating in conversations one on one? **Yes** □ **No**□ **or in a group** **Yes** □ **No**□

Occupational Therapy

How are you managing with your household tasks?

Please add comments:

Do you have a valid driver's license? **Yes** □ **No**□

Please add comments:

Current employment status: Retired □ **Unemployed**□ **Working** □ **School** □

Employment:

Social Work

Sometimes during recovery from stroke, people struggle with the following:

If any of these been a problem for you and/or your family or spouse? If so, please check above accordingly.

□ Stress

□ Financial Difficulties

□ Emotional changes and/or tearfulness

□ Depression

□ Anxiety

□ Grief and/or feelings of loss

□ Trouble adjusting to life after stroke

□ Relationship problems with loved one(s)

□ Caregiver challenges

□ Other:___________________________________