



KFMC Patient's Rehabilitation Referral Form
 (Please fill the form legibly and completely)

Referring Hospital: _____ Tel : _____ Ext. _____ Fax : _____	To : KFMC Tel : 01.288.9999 Ext. 8293/8245 Fax: 01.465.7160 For Follow-up: 800.127.7000
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Referring Hospital Emergency Coordinator Name: _____

Patient's (Full) Name: _____	Age: _____	Gender: _____
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Saudi National ID Number (Attach legible copy please)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>										

Location: <input type="checkbox"/> ER <input type="checkbox"/> Ward ___ Bed No.: _____	MRN: _____
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Referred to (Specialty): _____

Diagnosis: _____ **Date of Injury / Event:** _____

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Past History: _____

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Other co-morbid conditions: _____

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• **Bed Sores** (describe): Size: Depth (Grade) Site:

• **Breathing status:** On Ventilator Tracheostomy On oxygen Normal

• **Bladder:** Continent Incontinent **Bowel:** Continent Incontinent

Swallowing: Regular Diet Tube Feeding (NGT) PEG Tube Mechanical Soft Pureed

Communication:

1. Able to express him/herself? Yes No

2. Oriented to Time/Self/Place? Yes No

Mental status including (cognitive mode):

1. Can the patient follow commands? Yes No

2. Does the patient have the ability and will to participate in at least 3 sessions of therapy/day? Yes No

Has the family been explained about the nature and prognosis of disease? Yes No

Mobility:

• **Bed Mobility:** Independent Needs Help Total Care

• **Transfer (Bed to chair):** Independent Needs Help Unable

• **Ambulation:** Independent Needs Help: Unable

• **Distance:** _____ using walker cane wheelchair

Muscular skeletal status (as muscle power, ROM and any deformities):

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Self-Care:

• **Eating /Grooming:** Independent Needs Help Unable

• **Dressing:** Independent Needs Help Unable

Current Medication:

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Management:
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Current MRSA Screening (within 10 days):
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Services Required:
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Status: Stable Unstable
Means of Transportation:
 Ambulance Personal
 Others

Referring Doctor: **Signature** **Date**

Approved by:

Name and Code

Position:

Signature:

Comments / Additional Information:

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- Notes 1: NO PATIENT will be accepted at KFMC without completing this form by the referring hospital.**
- 2: Only Pre-Approved Referring Hospital will be accepted.**
- 3: Please review the below eligibility criteria for inpatient admission.**

Admission Criteria for Acute Inpatient Rehabilitation :

- 1. The patient must be willing and able to actively participate in the rehabilitation program.
- 2. The patient must have goals in at least two of the three major therapy areas (PT, OT and Speech).
- 3. The patient must have the endurance to tolerate at least three hours of therapy over the course of the day.
- 4. The patient must demonstrate the ability to carry over new information.
- 5. The patient must be medically stable.

Criteria for medical stable patient:

- 1. Patient must be afebrile for 48 hours; may have low grade temperature if a source has been identified and a treatment plan is in place.
- 2. Patients who are ventilator-dependent (e.g., those with high quadriplegia) must be stable on a portable ventilator for at least 48 hours.
- 3. Patient must not require suctioning more frequently than every four hours.
- 4. Patients need to have a stable cardiac rhythm.
- 5. Patients who require oxygen must have adequate oxygen saturation on portable oxygen.
- 6. Patient must be off continuous positive airway pressure (CPAP), except for treatment of sleep apnea.
- 7. If patient has a chest tube, it must be stable to gravity only for at least 48 hours.
- 8. The patient's medical work-up must be complete.

If a patient has nutritional, pain, or wound issues, they must be manageable and not interfere with therapies.