



Visit Details

1. Facility Name:

2. Facility Arrival Date:

(Record the earliest documented date. If participant transferred from acute at the same facility, please enter date of transfer to rehab.)

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

3. Facility Arrival Time:

(Record the earliest documented time. If participant transferred from acute at the same facility, please enter time of transfer to rehab.)

		:		
HH			MM	

 24 hour clock

Enter full or partial time.

4. Facility Discharge Date:

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

5. Facility Discharge Time:

		:		
HH			MM	

 24 hour clock

Enter full or partial time. If no details available, check Unknown.

Unknown

Visit Details - continued

6. a) Discharge Destination:

- Hospital** (Rehabilitation hospital for ongoing SCI-related care as well as mental hospital, or other acute care hospital for management of continuing medical issues after spinal cord injury-related care and/or rehabilitation is completed. This does not include long term care in a hospital setting.)

Name of Hospital: _____

b) Level of Care:

(check ONE response only)

- Acute
 Rehab
 Transitional Care
 Other (specify): _____
 Unknown

- Private residence** (includes house, condominium, mobile home, apartment, or houseboat)
- Assisted living residence** (semi-independent housing, a middle option between home support and residential care)
- Nursing home/ Long-term care within a hospital setting** (includes skilled nursing facilities and institutions providing long-term, custodial, chronic disease care, and extended care)
- Group living arrangement** (includes transitional living facility or any residence shared by non-family members)
- Hotel/motel** (includes short or long-term living arrangements, single room occupancy, etc.)
- Correctional institute** (includes prison, penitentiary, jail, correctional centre, etc.)
- Homeless** (includes cave, car, tent, street, etc.)
- Morgue
- Other (specify): _____

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7. Physician Most Responsible for Rehab

Care: (physician or physiatrist [not resident or fellow] who provided overall direction of care)

Provide last name, first initial (and second initial if available).

Data Collection Details

Collected by: (please print name)		Initial Here:		Date Abstraction Completed:	YYYY-MM-DD
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