



# National Rehabilitation Reporting Service Data Rehab

NRS-Rehab

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**1. Referral Source:**

- ☐ Self/Family
- ☐ Inpatient Acute Unit, same facility
- ☐ Inpatient Acute Unit, different facility
- ☐ Rehab unit, same facility
- ☐ Rehab unit, different facility
- ☐ Ambulatory Care Service
- ☐ Private Practice
- ☐ Drug Dependency Service
- ☐ Community Services
- ☐ Residential Care Facility
- ☐ Legal Service
- ☐ Educational Agency
- ☐ Home Care Agency
- ☐ Other
- ☐ Not available
- ☐ Asked, unknown

**2. Referral Source  
Province/Territory:**

- ☐ NL
- ☐ PI
- ☐ NS
- ☐ NB
- ☐ QC
- ☐ ON
- ☐ MB
- ☐ SK
- ☐ AB
- ☐ BC
- ☐ NT
- ☐ YT
- ☐ NU
- ☐ Not Available
- ☐ Asked, Unknown
- ☐ Not Applicable

**3. Referral Source Facility  
Number:**

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**4. Date Ready for Admission to Inpatient Rehabilitation Known:**

- ☐ No, date not known  
☐ Yes, date known

**5. Date Ready for Admission:**

/   /    
 YYYY MM DD

Enter as much of the date as is known. If no details available, check Unknown.

- ☐ Unknown

**6. Admission Date:**

/   /    
 YYYY MM DD

Enter as much of the date as is known. If no details available, check Unknown.

- ☐ Unknown

**7. Pre-Discharge Living Setting:**

- ☐ Home without paid health services  
☐ Home with paid health services  
☐ Boarding house  
☐ Assisted living  
☐ Residential care  
☐ Shelter  
☐ Public place  
☐ Other  
☐ Acute care  
☐ Not available, temporarily  
☐ Asked, unknown

**8. Post-Discharge Living Setting:**

- ☐ Home without paid health services  
☐ Home with paid health services  
☐ Boarding house  
☐ Assisted living  
☐ Residential care  
☐ Shelter  
☐ Public place  
☐ Other  
☐ Acute care  
☐ Not available, temporarily  
☐ Asked, unknown

**9. Service Interruption Transfer Status:**

- ☐ No, client was not transferred  
☐ Yes, client was transferred

**10. Service Interruption #1 Start Date:**

/   /    
 YYYY MM DD

Enter as much of the date as is known. If no details available, check Unknown.

- ☐ Unknown

**11. Service Interruption #1  
Return Date:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

**12. Service Interruption  
Reason #1:**

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**13. Service Interruption #2  
Start Date:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

**14. Service Interruption #2  
Return Date:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

**15. Service Interruption  
Reason #2:**

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**16. Service Interruption #3  
Start Date:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

**17. Service Interruption #3  
Return Date:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

**18. Service Interruption  
Reason #3:**

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**19. Date Ready for Discharge:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

**20. Discharge Date:**

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 YYYY      MM      DD
☐ Unknown

Enter as much of the date as is known. If no details available, check Unknown.

- 21. Reason for Discharge:**
- ☐ Service goals met and discharged to community (permanent living setting)
  - ☐ Service goals met and referral/transfer to other unit/facility
  - ☐ Service goals not met and referral/transfer to other unit/facility (change in health status)
  - ☐ Facility/agency withdrew services
  - ☐ Client withdrew
  - ☐ Client no longer eligible (funding)
  - ☐ Client moved
  - ☐ Client deceased
- 22. If reason for discharge = 1-2 (Service goals met), then Referred to code:**
- ☐ Inpatient acute unit, same facility
  - ☐ Inpatient acute unit, different facility
  - ☐ Rehabilitation unit, same facility
  - ☐ Rehabilitation unit, different facility
  - ☐ Ambulatory care services (facility based)
  - ☐ Private practice (primary care services, e.g., MD, PT)
  - ☐ Drug dependency service
  - ☐ Community services (including public health, transportation services)
  - ☐ Residential Care facility (includes long term care, continuing care, nursing home)
  - ☐ Legal service (police, parole officer, court)
  - ☐ Educational Agency
  - ☐ Home Care Agency
  - ☐ Other (includes rehabilitation outreach services)
  - ☐ Not available, temporarily
  - ☐ Asked, unknown
  - ☐ Not applicable
- 23. If reason for discharge = 1-2 (Service goals met), Referred to province or territory:**
- \_\_\_\_\_
- 24. If reason for discharge = 1-2 (Service goals met), Referred Facility Number:**
- \_\_\_\_\_
- 25. Pre-Admit Co-Morbid Procedure or Intervention CCI:**
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**26. Most Responsible Health Condition (ICD-10-CA code):**

\_\_\_\_\_

**27. Pre-Admit Co-Morbid Health Conditions (ICD-10-CA code):**

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**28. Post-Admit Co-Morbid Health Conditions (ICD-10-CA code):**

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**29. Functional Independence Measure at Admission**

Instructions: This questionnaire asks your opinion about how much assistance you need from a helper to perform daily activities, as well as necessary modifications to the activity or environment. Note: If an activity is something that you do not do at all (because it would be too unsafe or for any reason), answer "Total Assistance".

**Self-Care:**

- a) Eating \_\_\_\_\_
- b) Grooming \_\_\_\_\_
- c) Bathing \_\_\_\_\_
- d) Dressing – Upper Body \_\_\_\_\_
- e) Dressing – Lower Body \_\_\_\_\_
- f) Toileting \_\_\_\_\_

**Sphincter Control:** g) Bladder Management \_\_\_\_\_

h) Bowel Management \_\_\_\_\_

**Transfers:** i) Bed, Chair, Wheelchair \_\_\_\_\_

j) Toilet \_\_\_\_\_

k) Tub, Shower \_\_\_\_\_

**Locomotion:** l) Walk, Wheelchair \_\_\_\_\_☐ Walk \_\_\_\_\_☐ Wheelchair \_\_\_\_\_☐ Both \_\_\_\_\_

m) Stairs \_\_\_\_\_

**Communication:** n) Comprehension \_\_\_\_\_☐ Auditory \_\_\_\_\_☐ Visual \_\_\_\_\_☐ Both \_\_\_\_\_

o) Expression \_\_\_\_\_

☐ Vocal \_\_\_\_\_☐ Non-vocal \_\_\_\_\_☐ Both \_\_\_\_\_**Social Cognition:** p) Social Interaction \_\_\_\_\_

q) Problem Solving \_\_\_\_\_

r) Memory \_\_\_\_\_

**Date FIM at  
Admission  
Completed:**   

YYYY

/  

MM

/  

DD

Enter as much of the date  
as is known. If no details  
available, check Unknown.☐ Unknown**\*NOTE: Leave no blanks; enter 1 if not testable due to risk.****FIM LEVELS****No Helper**

7 Complete Independence (Timely, Safely)

6 Modified Independence (Device)

**Helper - Complete Dependence**

5 Supervision

4 Minimal Assistance (Subject = 75% + )

3 Moderate Assistance (Subject = 50% + )

**Helper - Complete Dependence**

2 Maximal Assistance (Subject = 25% + )

1 Total Assistance (Subject = 0% + )

*Taken from: Uniform Data System for Medical Rehabilitation (Copyright 1997)**Adult FIM / USA & Canada*

**30. Functional Independence Measure at Discharge**

Instructions: This questionnaire asks your opinion about how much assistance you need from a helper to perform daily activities, as well as necessary modifications to the activity or environment. Note: If an activity is something that you do not do at all (because it would be too unsafe or for any reason), answer "Total Assistance".

**Self-Care:**

- s) Eating \_\_\_\_\_
- t) Grooming \_\_\_\_\_
- u) Bathing \_\_\_\_\_
- v) Dressing – Upper Body \_\_\_\_\_
- w) Dressing – Lower Body \_\_\_\_\_
- x) Toileting \_\_\_\_\_

**Sphincter Control:**

- y) Bladder Management \_\_\_\_\_
- z) Bowel Management \_\_\_\_\_

**Transfers:**

- aa) Bed, Chair, Wheelchair \_\_\_\_\_
- bb) Toilet \_\_\_\_\_
- cc) Tub, Shower \_\_\_\_\_

**Locomotion:**

- dd) Walk, Wheelchair { ☐ Walk \_\_\_\_\_  
☐ Wheelchair \_\_\_\_\_  
☐ Both \_\_\_\_\_
- ee) Stairs \_\_\_\_\_

**Communication:**

- ff) Comprehension { ☐ Auditory \_\_\_\_\_  
☐ Visual \_\_\_\_\_  
☐ Both \_\_\_\_\_
- gg) Expression { ☐ Vocal \_\_\_\_\_  
☐ Non-vocal \_\_\_\_\_  
☐ Both \_\_\_\_\_

**Social Cognition:**

- hh) Social Interaction \_\_\_\_\_
- ii) Problem Solving \_\_\_\_\_
- jj) Memory \_\_\_\_\_

**Date FIM at  
Discharge  
Completed:**

/   /    
 YYYY MM DD

☐ Unknown

Enter as much of the date  
as is known. If no details  
available, check Unknown.

**\*NOTE: Leave no blanks; enter 1 if not testable due to risk.**

**FIM LEVELS**

***No Helper***

- 7 Complete Independence (Timely, Safely)
- 6 Modified Independence (Device)

***Helper - Complete Dependence***

- 5 Supervision
- 4 Minimal Assistance (Subject = 75% + )
- 3 Moderate Assistance (Subject = 50% + )

***Helper - Complete Dependence***

- 2 Maximal Assistance (Subject = 25% + )
- 1 Total Assistance (Subject = 0% + )

*Taken from: Uniform Data System for Medical Rehabilitation (Copyright 1997)*

*Adult FIM / USA & Canada*

## Data Collection Details

<b>Collected by:</b> (please print name)		<b>Initial Here:</b>		<b>Date of Data Extract:</b>	YYYY-MM-DD
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