

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:** _____

4. Date Ready for Admission to Inpatient Rehabilitation Known:

- No, date not known
- Yes, date known

5. Date Ready for Admission:

				/			/		
YYYY					MM			DD	

- Unknown

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

6. Admission Date:

				/			/		
YYYY					MM			DD	

- Unknown

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

- Unknown

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

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

				/			/		
YYYY					MM			DD	

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

Unknown

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

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

				/			/		
YYYY					MM			DD	

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

Unknown

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

				/			/		
YYYY					MM			DD	

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

Unknown

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

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

				/			/		
YYYY					MM			DD	

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

Unknown

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

				/			/		
YYYY					MM			DD	

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

Unknown

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

19. Date Ready for Discharge:

				/			/		
YYYY					MM			DD	

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

Unknown

20. Discharge Date:

				/			/		
YYYY					MM			DD	

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

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):

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

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

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

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	

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
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- 3 Moderate Assistance (Subject = 50% +)

Helper - Complete Dependence

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

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Data Collection Details					
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Collected by: (please print name)		Initial Here:		Date of Data Extract:	YYYY-MM-DD
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