G.F. Strong Rehab Centre
A part of the Vancouver Coastal Health Authority

Intensive Rehab Day Program (IRDP) Checklist

Name: _____

DOB: _____

MRN: _____

If addressograph is unavailable please PRINT this information in the above space 1.Patient Name 2.Record Number 3.Attending Physician 4.Date of Birth

Current GFS Inpatient Team: **ABI** ☐ **NMS** ☐ **SCI** ☐ **TRU** ☐
Acute Site: ☐_____
Community Referral: ☐__ **Client Email address:** _____

	YES	NO
Is client 16 years of age or older?		
Is client a resident of Vancouver Coastal Health?		
If client is not a resident of VCH**,** is there an early supported discharge program available that they could access in their community?		
Is client medically stable?		
Has client been in hospital/rehab 8 weeks or less?		
Does client require intensive therapy from a minimum of 2 core disciplines (ie: OT, PT, SLP)		
Does client have the activity tolerance to participate in therapy up to 4-6 hours per day, 4-5 days per week?		
Can client achieve functional goals within a 4-6 week period?		
Can client and /or family organize and afford transportation to and from GFS? • Transportation will be: ☐ driven by family/friend ☐ public transit ☐ Handi-dart : Handi-dart #:_____		
Will client have the means to pay for meals and prescriptions upon discharge?		
Can client manage personal care including toileting or do they have a family member to assist throughout the day		
Can client feed self independently or do they have a family member to assist for meals and/or snacks?		
Can client manage mobility/transfers independently or do they have a family member to assist throughout the day?		
Can client manage his/her medications, including pain management or do they have a family member to assist throughout the day?		
Is client waiting for equipment? If yes: ☐ funding has been confirmed ☐ equipment has been ordered ☐ client will be provided with loaner equipment		
Can client demonstrate manageable behaviour in an open/active group setting?		
Does client have MSP coverage or other funding secured?		
Does client have 3rd party funding?		
Is client aware of referral and motivated and willing to participate?		

Please submit **this form along with one of the following** by email to GFSadmissions@vch.ca or if no scan available fax **(604-730-7904)**
GFS inpatient team: Inter Team Transfer form
****Acute site or Community referral:** GFS Outpatient referral form + supporting documentation.

If you have any concerns regarding a client's eligibility into IRDP please contact the team coordinator @ 604-737-6272