



## VISIT DETAILS

## Rehab

## CHART ABSTRACTION

VD-Rehab

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## 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.

[Traumatic participants require the form "visit details and clinical information non-participating facility" if they have visited non-RHSCIR facilities directly before being admitted to your facility.](#)

3. a) For non-traumatic participants only, if they arrived from a hospital, what hospital did they come from?

-

  
 (name of hospital)

## b) Level of Care:

(check ONE response only)

☐ Acute☐ Rehab☐ Transitional care☐ Other (specify):

## 3. Facility Arrival Time:

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

 :  24-hour clock  
 HH MM

Enter full or partial time

☐ Unknown

## 4. Facility Discharge Date:

 /  /   
 YYYY MM DD

Enter as much of the date as is known.

5. Facility Discharge Time:

 :  24-hour clock  
 HH MM

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

☐ Unknown

## CHART ABSTRACTION

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Page 2 of 3**Visit Details—continued****6.5.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: \_\_\_\_\_

- ☐ **Private residence** (includes house, condominium, mobile home, apartment, or houseboat)

**b) Level of Care:**

(check ONE response only)

- ☐ Acute  
☐ Rehab  
☐ Transitional Care  
☐ Other (specify): \_\_\_\_\_  
☐ Unknown

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- ☐ **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)

## CHART ABSTRACTION

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- ☐ **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):** \_\_\_\_\_

**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

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