



# 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. Postal Code of Residence:** First 3 digits

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5. **Aboriginal/Indigenous Status:** \_\_\_\_\_
6. **Rehabilitation Client Group (RCG) at admission to rehab facility:** \_\_\_\_\_
7. **ASIA Impairment Scale (Spinal Cord Injury):** \_\_\_\_\_
8. **The client's height (cm) at time of admission:**
9. **The client's weight (kg) at time of admission:**
10. **Date Ready for Admission to Inpatient Rehabilitation Known:** ☐ No, date not known  
☐ Yes, date known
11. **Date Ready for Admission:**     /   /    
 YYYY MM DD  
☐ Unknown Enter as much of the date as is known. If no details available, check Unknown.
12. **Admission Date:**     /   /    
 YYYY MM DD  
☐ Unknown Enter as much of the date as is known. If no details available, check Unknown.
13. **Pre-Admission 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
14. **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

15. Pre-Hospital Vocational Status: \_\_\_\_\_

16. Post-Hospital Vocational Status: \_\_\_\_\_

**17. Follow Up Living Arrangements:**

**The individual(s) with whom the client is living after discharge from the rehabilitation facility/unit, at time of follow-up assessment. Refers to permanent living arrangements.**

- ☐ Partner/spouse
- ☐ Family member
- ☐ Non-family, unpaid (e.g., roommate)
- ☐ Paid attendant
- ☐ Alone
- ☐ Other (specify): \_\_\_\_\_
- ☐ N/A – I will be living in a nursing home, hospital or correctional institute

**18. Follow Up 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

19. Follow Up Vocational Status: \_\_\_\_\_

**20. Service Interruption  
Transfer Status:**

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

**21. a) Service Interruption #1  
Start Date:**

/   /    
YYYY MM DD

☐ Unknown

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

**b) Service Interruption #1  
Return Date:**

/   /    
YYYY MM DD

☐ Unknown

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

**c) Service Interruption  
Reason #1:**

\_\_\_\_\_

**d) Service Interruption #2****Start Date:**

				/			/		
YYYY					MM			DD	

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

☐ Unknown**e) Service Interruption #2****Return Date:**

				/			/		
YYYY					MM			DD	

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

☐ Unknown**f) Service Interruption****Reason #2:**

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**g) Service Interruption #3****Start Date:**

				/			/		
YYYY					MM			DD	

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

☐ Unknown**h) Service Interruption #3****Return Date:**

				/			/		
YYYY					MM			DD	

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

☐ Unknown**i) Service Interruption****Reason #3:**

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**22. Date Ready for Discharge:**

				/			/		
YYYY					MM			DD	

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

☐ Unknown**23. Discharge Date:**

				/			/		
YYYY					MM			DD	

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

☐ Unknown**24. 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

**25. 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

**26. If reason for discharge = 1-2 (Service goals met), Referred to province or territory:**

\_\_\_\_\_

**27. If reason for discharge = 1-2 (Service goals met), Referred Facility Number:**

\_\_\_\_\_

**28. Primary Reason Waiting for Discharge:**

\_\_\_\_\_

**29. Secondary Reason Waiting for Discharge:**

\_\_\_\_\_

**30. Rehabilitation Time with an OT:**

:    
HH MM

24 hour clock

**31. Rehabilitation Time with a PT:**

:    
HH MM

24 hour clock

**32. Rehabilitation Time with an OT Assistant:**

:    
HH MM

24 hour clock

**33. Rehabilitation Time with a PT Assistant:**

:    
HH MM

24 hour clock

**34. Pre-Admit Co-Morbid Procedure or Intervention CCI:**

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

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

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

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**38. 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 

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- b) Grooming 

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- c) Bathing 

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- d) Dressing – Upper Body 

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- e) Dressing – Lower Body 

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- f) Toileting 

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**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 &amp; Canada

**39. 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:**

- 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  
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**

**Collected by:**  
(please print name)

**Initial  
Here:**

**Date of Data  
Extract:**

YYYY-MM-DD