



# 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. 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:**

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**9. The client's weight (kg) at time of admission:**

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**10 Date Ready for Admission to**☐ No, date not known**4. Inpatient Rehabilitation Known:**☐ Yes, date known**11 Date Ready for Admission:**

				/			/		
YYYY					MM			DD	

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

**5.**☐ Unknown**12 Admission Date:**

				/			/		
YYYY					MM			DD	

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

**6.**☐ Unknown**13 Pre-~~Admission~~Discharge Living****7. 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:****8.**

- ☐ 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**

**9. Transfer Status:**

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

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

/   /    
 YYYY MM DD

☐ Unknown

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

**11. 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.

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

\_\_\_\_\_

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

/   /    
YYYY MM DD

☐ Unknown

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

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

/   /    
YYYY MM DD

☐ Unknown

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

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

\_\_\_\_\_

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

/   /    
YYYY MM DD

☐ Unknown

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

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

/   /    
YYYY MM DD

☐ Unknown

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

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

\_\_\_\_\_

**22. Date Ready for Discharge:**

**19.**

/   /    
YYYY MM DD

☐ Unknown

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

**23. Discharge Date:**

**0.**

/   /    
YYYY MM DD

☐ ☐ Unknown

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

**24 Reason for Discharge:****1.**

- ☐ 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:****3.**

\_\_\_\_\_

**27 If reason for discharge = 1-2 (Service goals met), Referred Facility Number:****4.**

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

**30. Rehabilitation Time with an OT:**   :   [24 hour clock](#)  
HH MM

**31. Rehabilitation Time with a PT:**   :   [24 hour clock](#)  
HH MM

**32. Rehabilitation Time with an OT Assistant:**   :   [24 hour clock](#)  
HH MM

**33. Rehabilitation Time with a PT Assistant:**   :   [24 hour clock](#)  
HH MM

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

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

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

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

**38 Functional Independence Measure at Admission****29.**

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*

### **39 Functional Independence Measure at Discharge**

**0.**

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)a)** Eating

\_\_\_\_\_

**t)b)** Grooming

\_\_\_\_\_

**u)c)** Bathing

\_\_\_\_\_

**v)d)** Dressing – Upper  
Body

\_\_\_\_\_

**w)e)** Dressing – Lower  
Body

\_\_\_\_\_

**x)f)** Toileting

\_\_\_\_\_

#### **Sphincter Control:**

**y)g)** Bladder  
Management

\_\_\_\_\_

**z)h)** Bowel  
Management

\_\_\_\_\_

#### **Transfers:**

**aa)i)** Bed, Chair,  
Wheelchair

\_\_\_\_\_

**bb)j)** Toilet

\_\_\_\_\_



**Locomotion:** cc)k) Tub, Shower \_\_\_\_\_

dd)l) Walk, Wheelchair { ☐ Walk \_\_\_\_\_  
☐ Wheelchair \_\_\_\_\_  
☐ Both \_\_\_\_\_

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

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

gg)o) Expression { ☐ Vocal \_\_\_\_\_  
☐ Non-vocal \_\_\_\_\_  
☐ Both \_\_\_\_\_

**Social Cognition:** hh)p) Social Interaction \_\_\_\_\_

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

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