

# Rehabilitation/Geriatrics



Winnipeg Regional  
Health Authority

*Caring for Health*

Office régional de la  
santé de Winnipeg

*À l'écoute de notre santé*

## Coordinated Entry System



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Rehabilitation Services occur on five sites within the WRHA:



## **WRHA Rehabilitation & Geriatrics Program Coordinated Entry System**

### **What is the Coordinated Entry System?**

One waiting list for multiple rehabilitation and geriatric services offered at five facilities in Winnipeg.

### **Why does this list exist?**

To provide the most appropriate care to the right client in the right place at the right time, to minimize the need to understand the multiple criteria and services offered within the programs and to maximize the ability to match available beds to the individual client's needs.

### **Who is the "right client"?**

The programs offer services for clients who are medically stable with functional limitations and potential to benefit from rehabilitation services. Examples include stroke, respiratory and fracture rehabilitation, restoration from disabling illnesses or surgeries and management of complex conditions of the elderly. Medically stable clients who do not require extensive diagnostic testing, multiple procedures or intensive medical or nursing care may be appropriate clients. The services cannot accommodate all clients requiring alternate levels of care.

### **How does it work?**

To be on the waiting list, clients need to be assessed by one of the health professionals associated with the Rehab/Geriatrics Program. If a client is already seeing a clinical specialist, their specialist can make the referral. Clients or referring agencies unsure of how to receive an assessment can contact the number below for assistance. The Program Director will help find an appropriate clinician to assess the client for program services.

One of the health professionals associated with the Rehab/Geriatrics Program will review the referral for acceptance onto the wait list. **All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

The referral form includes basic client demographic and clinical information, as well as the name and phone number of a health professional familiar with the client. A copy of the consult or specialist progress notes, in addition to collateral information should be sent with the referral form via fax to 982-0144.

When a bed becomes available, the contact person will be phoned to obtain current clinical information. The client will be offered the first available bed on a Rehabilitation Unit.

### **What happens if a client gets really ill while on a Rehabilitation unit?**

The client will be transferred back to the hospital.

For further information, contact the Administrative Assistant, Coordinated Entry System  
Phone: 831-2914 Fax: 982-0144

# Geriatric Rehabilitation Program

Deer Lodge Centre, Riverview Health Centre, Seven Oaks Hospital, St. Boniface Hospital  
(149 beds across the 4 sites)

## Description

The Geriatric Rehabilitation Program provides interdisciplinary care for clients in the geriatric population (65 years and older) with age-related medical problems. The program will provide assessment and rehabilitation to individuals who have the potential to return to community living.

**All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

## Criteria for Admission

- Patients require a consultation by Geriatric Medicine or review by a member of the Rehabilitation and Geriatrics Program (i.e. GPAT, R&G Clinician, Geriatric CNS) prior to being considered for admission. In cases expected to entail unusual nursing care demands, consultation will be sought with the Program Team Manager.
- Patients must be 65 years of age or older. Patients who are under 65 years of age are considered on a case by case basis.
- Patients must be medically stable; on-site medical staff is not available for the entire day and patients should be manageable with physician visits 2 to 3 times weekly.
- Patients with cognitive impairment from dementia or delirium may be accepted providing that their behaviour can be managed on the ward without resorting to constant care or locked units.
- Patients should have potential to learn and retain rehabilitative treatment regimens.
- Patients must be willing and able to participate in therapy, i.e. able to sit up from 1-3 hours, or to actively participate in at least 1 hour of therapy daily.
- Patients with purely psychiatric or behaviour control issues will not normally be considered for admission.
- Advanced directives should be discussed and documented by the attending physician prior to transfer.
- Patients should have a reasonable expectation to return to a community living arrangement.
- Patients will require at least two weeks rehabilitation in hospital.
- Patients who require 24-hour rehabilitation nursing care and/or supervision.
- Admissions will be prioritized by date of referral as well as case mix.
- Clients with the following will be considered on a case by case basis for service at DLC only: CAPD; Non-weight Bearing; PICC Lines; Dialysis; Antibiotic Resistant Organisms

# Amputee (Inpatient) Program

Health Sciences Centre  
(9 beds on HSC site)

## Description

- The Amputee (Inpatient) Program provides service for patients with recent or remote upper and lower extremity amputations who require improved cardiovascular endurance; functional independence and/or prosthetic training with interdisciplinary team care.

**All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

## Criteria for Admission

- Patients not requiring 24 hour care, but who are unable to live in the community during the rehabilitation phase due to the following factors:
  - Medical
  - Environmental
  - Geographical
  - Social
- Patients who are considered medically and surgically stable by the Director of Amputee Program or the delegate (i.e. cardiac, respiratory, neurological, musculoskeletal, vascular and wound status).
- Patients who have intact weight bearing skin surfaces, enabling active participation in rehabilitation.
- Patients who demonstrate adequate cognitive and physical potential to achieve either prosthetic ambulation or wheelchair independence.
- Patients of uncertain potential may be considered for admission for a four-week trial period. If the admission proves unsuccessful, the patient will be discharged from the program.
- Patients who can tolerate at least one hour of active participation in therapy per day.
- Selection of prioritization for admission will be done on a regular basis with the Program Team.
- Admissions will be prioritized by date of referral as well as case mix.

# Neuro-musculoskeletal Program

Health Sciences Centre  
(7 beds at HSC)

## Description

The Neurolocomotor Program of Rehabilitation Medicine provides comprehensive care for patients with multiple fractures, complex trauma, myopathy, neuromuscular junction disorders, polyneuropathy ( inherited & acquired) , motor neuron disease, burn rehabilitation, and reconditioning after complex medical illness.. Usually these patients are taken from the acute phase into the active phase of the rehabilitation and then discharged back to the community. Patients may also be accepted with other rehabilitation related diagnoses, but patient must demonstrate potential for improved outcome. The interdisciplinary team will provide care for the patients during the active rehabilitation phase.

The program accepts patients from all hospitals within the city of Winnipeg, the rural areas of Manitoba, Nunavut and Northwestern Ontario.

**All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

## Criteria for Admission

- Patients with impairments from the above diseases who are medically stable.
- Require 24 hour nursing care in the rehabilitation area.
- Patient must have an appropriate discharge destination or options for discharge identified prior to admission.
- Requires physician assessment/oversight, program coordination, and medical specialty services, at a minimum of three times per week.
- Requires retraining in functional areas such as mobility, ADL's, IADL's, communication, speech and swallowing.
- Requires specialized therapeutic skills or equipment, social work services or interdisciplinary care not otherwise appropriate in the community.
- The patient has shown improvement to date and has the potential for continued functional gains.
- Achievable rehabilitation goals have been identified.
- The patient has the ability to learn new activities and follow direction.
- The patient's condition must have the likeliness of benefitting from focused inpatient rehabilitation.
- The patient must be able to understand and retain instructions.
- The patient must be capable of learning.
- The patient has agreed to demonstrate co-operative behaviour.
- The patient has expressed a willingness to participate in a rehabilitation program.
- The patient is able to tolerate increasing amounts of therapy starting at 30 minutes per day.
- Admissions will be prioritized by date of referral as well as case mix.

# Spinal Cord Injury Program

Health Sciences Centre  
( 13 Beds at HSC)

## Description

This is a tertiary level interdisciplinary rehabilitation program for people with sub-acute spinal cord lesions resulting in paraplegia or tetraplegia.

Age 16 and up are considered. All are accepted on case-by-case basis depending on the following: pre-morbid function, prognosis, co-morbidities and ability to participate in an intensive rehabilitation program.

**All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

## Criteria for Admission

- All patients must be aged 16 and over and have spinal cord pathology or similar neurological impairment as deemed by the Director of the Spinal Cord Injury Program or a Designate.
- All patients must be deemed medically stable by either the Director of the Spinal Cord Injury Program or the designate (e.g. VS stable, stable cardiac, respiratory and neurological status).
- All patients must be able to participate in and benefit from an active rehabilitation program (e.g. At least 2 hours per day of therapy).
- Selected patients from the community who require a coordinated team approach for functional reassessment and who also may require 24-hour nursing care. Realistic functional goals must be obtainable.
- Selected patients may be admitted for post-surgical care and rehabilitation (up to two at any one time). Patients who are in the pre-operative state of pressure sore care will not be considered.
- Selected patients may be admitted for initial care and rehabilitation and planned transfer to a long-term facility, in order to improve overall quality of life.
- Selected patients with a terminal diagnosis will be considered on a case-by-case basis for a trial of short-term rehabilitation.
- A patient who fits any of the above criteria but also has an established Portable Ventilator (Lp6 or Lp10). \*\*Note this has been put on hold as of 2007.
- The priority, timing and order of admission will be determined from the waiting list of approved applications by the Director of the Spinal Cord Injury Program or the Designate. The order and timing will be based on several issues including: the urgency of rehabilitation needs of the patient, the ability to participate in active rehabilitation, the medical and physical stability of the patient, the present resource, care and bed issues on RR5, and any specific equipment issues that need to be accounted for.

# Acquired Brain Injury Program

## Riverview Health Centre

### Description

The Acquired Brain Injury Program provides comprehensive interdisciplinary care for adults with neurological damage as a result of acquired brain injury. The interdisciplinary team typically provides its services over a period of four to eight weeks. Patients are assessed and provided with treatment and care. Patient progress is monitored at regular intervals to ensure maximum benefit from rehabilitation services is being achieved. The programs typically address the areas of:

- Physical functioning
- Cognitive functioning
- Behavioural and emotional functioning
- Social and community functioning.

Access to the Acquire Brain Injury rehabilitation program is coordinated through the WRHA Rehab/Geriatrics Program Coordinated Entry System.

**All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

The Acquired Brain Injury Program has 10 beds on its unit.

### Criteria for Admission

The program primarily addresses the rehabilitation needs of patients with neurological impairments and disabilities related to traumatic injuries of the brain. Individuals with other pathologies such as tumours, infections and anoxic damage (including those with CVA's) may be admitted if they demonstrate potential to benefit from the program's specialized resources.

In assessing an application for admission the following factors are considered:

- Age 16 and over
- Demonstrated medical stability
- Demonstrated potential to benefit from active rehabilitation within a period of 4 – 8 weeks
- Requires 24-hour rehabilitation nursing care and/or supervision
- Admissions will be prioritized by date of referral as well as case mix.
- Requires specialized care by Physical Medicine and Rehabilitation physicians for the prevention and/or treatment by more than one of the following disciplines:
  - Occupational Therapy
  - Physiotherapy
  - Rehabilitation Psychology/Neuropsychology
  - Speech and Language Pathology

Dependent upon patient needs the program will provide or have consultative services from Audiology, Clinical Nutrition, Home Care, Laboratory, Medical Specialists, Orthotics, Pharmacy, Therapeutic Recreation, Rehabilitation Engineering for special devices, Respiratory Therapy, Social Work, Spiritual Care and Vocational Rehabilitation.

# **Stroke Program**

## **Riverview Health Centre, Deer Lodge Centre**

### **(40 beds on 2 sites)**

#### **Description**

The Stroke Program provides comprehensive, interdisciplinary care for adults with neurological impairments due to cerebral vascular accidents. This care is provided from the active rehabilitation stage through discharge and community re-entry. Patients will be assessed and provided with treatment and care by an interdisciplinary team. Patient progress is monitored at regular intervals. The programs typically address the areas of physical, cognitive, behavioural and emotional, social and community functioning.

**All patients referred for rehabilitation must be accepted/approved by a physician within the R&G program.**

#### **Criteria for Admission**

In assessing an application for admission the following factors are considered:

- Age 18 and over
- Requires 24-hour rehabilitation nursing care
- Achievable rehabilitation goals have been identified
- Patients should have a reasonable expectation to return to community living
- Demonstrated medical stability
- Demonstrated potential to benefit from active rehabilitation within a period of 6-8 weeks and be willing/able to participate and benefit from 2-3 hours of daily therapy
- Patients should have the potential to comprehend, learn and retain rehabilitative treatment regimens
- Requires specialized care from Physical Medicine and Rehabilitation physicians for the prevention and/or treatment presenting conditions and for the completion of discharge planning and follow-up
- Admissions will be prioritized by date of referral as well as case mix.
- Requires assessment and treatment by one or more of the following disciplines physiotherapy, occupational therapy, speech and language pathology, rehabilitation psychology/neuropsychology
- Community patients who require 24 hour nursing care and a coordinated team approach for functional re-assessment will be considered on a case by case basis
- Advanced care directives should be discussed and documented by the attending physician prior to transfer

Dependent on patient needs the program will provide or have consultative services from Audiology, Clinical Nutrition, Home Care, Laboratory, Medical Specialists, Orthotics, Pharmacy, Social Work, Rehabilitation Engineering for special devices, Therapeutic Recreation, Respiratory Therapy and Spiritual Care.

# **Geriatric Mental Health Program**

## **Seven Oaks General Hospital**

**(19 beds)**

### **Description**

The Geriatric Mental Health Inpatient units at Seven Oaks General Hospital provide assessment and short-term treatment for the elderly who are experiencing symptoms attributed to a treatable psychiatric disorder or condition. The units are intended to complement, and work collaboratively with, existing health care services (i.e. family physicians, general hospitals, psychiatric units, crisis stabilization programs, Geriatric Mental Health outreach programs, geriatric inpatient and outpatient services and community mental health services).

**All patients referred for rehabilitation must be accepted/approved by a physician within the Mental Health program.**

### **Criteria for Admission**

To be eligible for admission to the Geriatric Mental Health inpatient unit, referred persons must meet the following criteria:

- Age 65 or over
- Requires 24-hour rehabilitation nursing care and/or supervision.
- Have a DSM IV Axis I psychiatric disorder, or require specialized Geriatric Mental Health intervention because the aging process has complicated a pre-existing psychiatric disorder, or experience a mental disorder or stress that is interfering with day-to-day functioning.
- Physical status has been assessed to rule out medical instability such as delirium, exacerbation of a chronic disease or pain management.
- The Family Physician is aware of, and in agreement with, the referral for admission.
- Personal Care Homes must ensure that the appropriate Geriatric Mental Health Team and its supporting psychiatrist have been consulted prior to initiating referral to the inpatient unit.
- Admissions will be prioritized by date of referral as well as case mix.

Typical situations would include a need for:

- Multidisciplinary assessment in a controlled environment.
- Differential diagnosis (i.e. cognitive impairment/depression).
- Stabilization of acute psychiatric problems or exacerbation of chronic mental illness.
- Alteration of medications requiring close monitoring.
- Specialized therapeutic interventions (i.e. individual counselling, group therapy, family intervention, behavioural interventions, medications, electroconvulsive therapy).
- Behavioural or psychiatric symptoms associated with dementia.

The Geriatric Mental Health unit provides acute care; therefore, the focus is on persons, for whom there is a reasonable expectation of a positive response to treatment.

## Site Contact List

### **Deer Lodge Centre**

Central Wait List Coordinator  
2109 Portage Avenue  
Winnipeg, MB R3J 0L3  
Phone: (204) 831-2914  
Fax: 982-0144

### **Health Sciences Centre**

RR5 – 800 Sherbrook Street  
Winnipeg, MB R3A 1M4  
Phone: 787-2382  
Fax: 787-4086

### **Riverview Health Centre**

Health Information Admitting Services  
1 Morley Avenue  
Winnipeg, MB R3L 2P4  
Phone: 478-6259  
Fax: 453-7593

### **St. Boniface General Hospital**

409 Taché Avenue  
Winnipeg, MB R2H 2A6  
Phone: 237-2409  
Fax: 237-2697

### **Seven Oaks General Hospital**

2300 McPhillips Street  
Winnipeg, MB R2V 3M3  
Phone: 632-3531  
Fax: 694-8304



**Rehab & Geriatrics Program Team**

C/o Deer Lodge Centre: 2<sup>nd</sup> Floor Admin Building  
2109 Portage Avenue  
Winnipeg, MB R3C 1A2

## CENTRAL WAIT LIST

**Dear Patient & Family Member/s:**

The Winnipeg Regional Health Authority (WRHA) Rehabilitation & Geriatrics Program Team has developed a Central Wait List to assist patients in their recovery process.

The purpose of this letter is to notify you that your name has been placed on the Rehabilitation & Geriatric Central Wait List.

The specific rehabilitation service/s you require are available at a number of different hospitals and long-term care facilities in the City of Winnipeg. The Central Wait List will match your needs to the resources you require.

When a bed becomes available with the resources to meet your specific rehabilitation needs, a member of your health care team will make a bed offer to you. The transfer to the new facility will result in you receiving the appropriate rehabilitation services as soon as possible, thereby assisting you to recover as quickly as you can. If you decline the offer of this bed, you may be required to pay a per diem cost for remaining in an acute care bed.

If you have any questions, please ask to speak with your Patient Care Team Manager.

Sincerely,

***On behalf of the WRHA Rehab & Geriatrics Program Team***

A handwritten signature in blue ink, appearing to read 'Réal Cloutier'.

Réal Cloutier,  
WRHA VP Long Term Care &  
Chief Allied Health Officer



**REHAB / GERIATRICS COORDINATED ENTRY REFERRAL FOR CENTRAL WAITING LIST** Phone (204) 831-2914

Complete all sections of the form & forward with required information to

**FAX (204) 982-0144**

<b>CLIENT INFORMATION</b>	NAME OF CLIENT			LANGUAGE SPOKEN		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
	ADDRESS			POSTAL CODE	PHONE #			
	DATE OF BIRTH		DD	MM	YYYY	MHSC	PHIN	
	NEXT OF KIN or CONTACT PERSON			RELATIONSHIP			PHONE #	
<b>SERVICE REQUESTED</b>	<b>SERVICE REQUESTED:</b>				<b>FAX REQUIRED INFORMATION, IF APPLICABLE:</b>			
	<input type="checkbox"/> GERIATRIC REHAB <input type="checkbox"/> ORTHO REHAB <input type="checkbox"/> AMPUTEE REHAB <input type="checkbox"/> NEURO REHAB (STROKE) <input type="checkbox"/> NEURO REHAB (NEUROMUSCULOSKELETAL) <input type="checkbox"/> NEURO REHAB (SPINAL CORD INJURY) <input type="checkbox"/> NEURO REHAB (ACQUIRED BRAIN INJURY) <input type="checkbox"/> RESPIRATORY REHAB <input type="checkbox"/> GERIATRIC MENTAL HEALTH (GMH) <input type="checkbox"/> OTHER				<input type="checkbox"/> GERIATRICIAN / PHYSIATRIST CONSULT <input type="checkbox"/> CNS / REHAB CLINICIAN CONSULT <input type="checkbox"/> GPAT CONSULT <input type="checkbox"/> PSYCHIATRY / GMH CONSULT <input type="checkbox"/> PROGRESS NOTES – INCLUDING: PT / OT / NURSING/ MEDICAL / SPEECH LANGUAGE PATHOLOGY / SOCIAL WORK <input type="checkbox"/> CURRENT MEDICATION LIST <input type="checkbox"/> PERTINENT X-RAYS / SCANS / LAB VALUES <input type="checkbox"/> REFERRAL LETTER & ADMISSION HISTORY (IF OUT OF REGION REFERRAL)			
<b>CLINICAL INFORMATION</b>	DIAGNOSIS & REHAB ISSUES / INCLUDE PRIOR FUNCTIONING (to be completed by physician / clinician):							
	EXPECTATIONS OF REHAB & DISCHARGE OUTCOME (to be completed by physician / clinician):							
	INDICATE IF ANY OF THE FOLLOWING APPLY: <input type="checkbox"/> PICC LINE <input type="checkbox"/> MRSA+ <input type="checkbox"/> VRE+ <input type="checkbox"/> C DIFF+ <input type="checkbox"/> NWB <input type="checkbox"/> BIPAP / CONTINUOUS O2 <input type="checkbox"/> PERITONEAL DIALYSIS <input type="checkbox"/> HEMODIALYSIS <input type="checkbox"/> REQUIRES MECHANICAL LIFT							
	PATIENT & FAMILY AWARE OF REFERRAL AND IN AGREEMENT WITH ADMISSION TO A REHAB BED AT FIRST AVAILABLE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NOT, WHAT RESTRICTIONS & WHY?							
	NAME OF REFERRING AGENCY		REFERRAL CONTACT		PHONE #	PAGER #		
	REHAB/GERIATRIC ASSESSMENT / CONSULT BY (indicate geriatrician, physiatrist, GPAT clinician):							
	CURRENT LOCATION OF PATIENT - SPECIFY FACILITY, UNIT & PHONE #					DATE OF REFERRAL		
<b>RETAIN ORIGINAL FORM ON CURRENT PATIENT CHART</b>								

**Guideline: Rehab / Geriatrics Program Coordinated Entry Referral Form for Central Waiting List**

**Date: November 8, 2006**

**Purpose / Background:**

**To capture a summary of patient information to assist in facilitating admission to a bed in the Rehab / Geriatrics Program.**

**To update the previous referral form to reflect changes in the Coordinated Entry System database.**

**Initiation:**

The referring source will initiate a consult to Rehab / Geriatrics. A specialist in the program (Geriatrician, Psychiatrist, GPAT (Geriatric Program Assessment Team) clinician will answer the consult to determine if appropriate for the Central Waiting List. If so, the referral form will be completed, & faxed with the collateral information to Coordinated Entry. If the referring source is outside of the Winnipeg region, they will complete the referral form & fax to Coordinated Entry with collateral patient information. A Geriatrician / Psychiatrist will review this to determine if appropriate. Out of region referrals could also be a physician to physician consult.

**Definitions:**

Coordinated Entry: A central intake that receives and coordinates referrals for inpatient rehab. Clients who have been accepted to the program are entered onto a Central Waiting List. These clients are matched to appropriate rehab / geriatric beds as they become available for admission.

**Use:** This form provides relevant information on a patient that a potential admission facility will need, along with collateral information, to help determine patient care needs in a rehab setting.

**Completion:**

**Client Information:** Provide demographics to maintain an accurate history in the database as some clients may have multiple referrals to this inpatient program.

**Service Requested:** Helps in determining which rehab unit would be most appropriate for client.

**Fax Required Information:** Collateral information from the chart that provides a more detailed profile of client's medical & functional status to help develop a care plan focusing on the individual's rehabilitation needs.

**Clinical Information:**

**Diagnosis & Rehab Issues / Include Prior Functioning** (to be completed by physician / clinician): Identify diagnosis & rehab issues to establish a care plan. An indication of prior functioning will provide a baseline of comparison to current status, & to help establish rehab goals.

**Expectations of Rehab & Discharge Outcome** (to be completed by physician / clinician): What outcome does the referral source expect from the rehab process? Are their goals realistic?

**Indicate if Any of the Following Apply:** Any of the following could be constraining factors to admission. Admission facilities should be made aware if any of these apply so that they can decide whether or not they are able to meet client care needs.

**Patient & Family Aware of Referral:** Must be aware of referral to the program, and agree to admission to a bed when one is offered. If patient / family are adamantly against a particular facility it should be mentioned here.

**Name of Referring Agency / Referral Contact / Phone # / Pager #:** This provides information regarding the origin of the referral as well as a contact person for Coordinated Entry or Admission facility to follow up with prior to making a bed offer.

**Rehab / Geriatric Assessment / Consult by:** Clients must be assessed & deemed appropriate by a qualified Physician / Clinician. Indicate who performed the assessment.

**Current Location of Patient - Facility, Unit & Phone #:** Admission facilities will use this information to contact the unit to make further inquiries, and to make a bed offer.

**Date of Referral:** Indicate the date the patient's referral was forwarded to Coordinated Entry.

**Filing / Routing:** The Coordinated Entry will fax a copy of the referral form, as well as collateral information, to a rehab facility in anticipation of a bed becoming available. The original referrals are kept in the Coordinated Entry Office for a period of 4-6 months, and then destroyed. The referral source should retain a copy of the referral form on the patient's chart.