|  |
| --- |
| **Referral Form** |
| Date of Referral  |  |
| Patient’s Name |  |
| Home Address  |  |
| **Inpatient**  |[ ]   Current Address of patient:  |
| **At Home** |[ ]   |
| **Other** |[ ]   |
| DOB:  | Age:  | NHS Number:  |
| Primary Diagnosis: |
| Date of onset:  |
| Brief summary of medical history:  |
| Previous physical & cognitive function:  |
| NOK Name  |  |
| Relationship to patient:  |  |
| NOK Address:  |  |
| Contact numbers:  | Email: |
| Eligibility for NHS funding confirmed? Yes [ ]  No [ ]  |
| Funding Authority  |  |
| Funding Contact Details   |  |
| Referred by  |  |
| Job Title:   | Organisation:  |
| Contact numbers: |  |
| Email:  |

|  |  |
| --- | --- |
| **Breathing** *(please tick as appropriate*)[ ]  Breathing disorders (e.g. COPD, asthma)[ ]  Tracheostomy [ ]  Cuffed [ ]  UncuffedType/size: Date last changed:[ ]  Ventilator [ ]  Oxygen *(please provide details i.e. continuous or not, amount)* | **Other relevant details:** |
| **Nutrition** *(please tick as appropriate)*[ ]  Oral diet [ ]  Modified consistency *(Please give details)*[ ]  Assistance with feeding (*Please give details)*[ ]  Enteral feeding *(Please specify port e.g. PEG, PEJ, RIG)* Date of insertion:**Weight:**  **Height:**  | **Other relevant details:** |
| **Elimination** *(please tick as appropriate)*[ ]  Continent[ ]  Needs assistance to toilet/commodeIncontinent of urine [ ]  Urethral catheter **Type/Size:** **Date last changed**  | [ ]  Suprapubic catheter **Type/Size:** **Date last changed**:[ ]  Incontinent of faeces **Other relevant details:** |
| **Tissue viability** *(please tick as appropriate)*[ ]  Skin intact[ ]  Pressure ulcer [ ]  Moisture lesionsWaterlow score:  | **Other relevant details** **including equipment:** |
| **Communication**[ ]  Able to communicate without assistance[ ]  Unable to communicate[ ]  Requires assistance for communication  | **Other relevant details**: |
| **Cognition**[ ]  Difficulty understanding and processing information[ ]  Memory problems[ ]  Low awareness state | **Other relevant details:** |
| **Mental Capacity**Full [ ]  Variable [ ]  None [ ] Date of latest Mental Capacity Assessment:   | **Additional Information:** |

|  |  |
| --- | --- |
| **Behaviour** *(please describe any problems)* [ ]  No problems with behaviour[ ]  Irritable at times[ ]  Impulsive[ ]  Verbally aggressive[ ]  Physically aggressive[ ]  Disinhibited[ ]  Lacks insight[ ]  1:1 supervision | **Other relevant details:** |
| **Psychological/Emotional**[ ]  No problems[ ]  Mood swings[ ]  Withdrawn [ ]  Anxiety[ ]  Depression[ ]  Suicidal tendency[ ]  Self-Harm | **Other relevant details:** |
| **Mobility** [ ]  Able to move or turn in bed independently[ ]  Able to move or turn in bed with assistance[ ]  Unable to move or turn in bed[ ]  Wheelchair user[ ]  Has own wheelchair/seating system[ ]  Has a wheelchair/seating system on loan[ ]  Has been referred to local wheelchair/special seating services | [ ]  Yet to be referred to wheelchair/special seating services[ ]  Using pressure relieving seat cushion**Other relevant details:** |
| **Transfers**[ ]  Able to transfer independently[ ]  Able to transfer with assistance [ ]  Requires full Ao2 for all transfers | **Other relevant details** (i.e. type of transfer equipment, type of sling) |
| **Posture Management****Please specify** (i.e. splinting regime, Botulinum Toxin injections, ITB, sleep system) |
| **Personal hygiene**[ ]  Independent[ ]  Supervision[ ]  Assistance | **Other relevant details** (i.e. how many staff, equipment) |
| **Social history**[ ]  Smoking[ ]  Alcohol [ ]  Drugs | **Please provide details** (i.e. current and premorbid patterns) |

|  |  |
| --- | --- |
| **Therapy interventions** [ ]  PT[ ]  OT[ ]  SLT[ ]  Music Therapy [ ]  Psychology | **Other relevant details**  |
| **Medication** |
| **Other specialist information:** (i.e.: Diabetes Management; haematology, oncology, rheumatoid conditions, clinics attended, external agencies involved)  |