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| **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: | | | | |

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| **Breathing** *(please tick as appropriate*)  Breathing disorders (e.g. COPD, asthma)  Tracheostomy  Cuffed  Uncuffed  Type/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/commode  Incontinent 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 lesions  Waterlow 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:** |

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| **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) |

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| **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) | |