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| **Dudley Rehabilitation Service Referral Form 2022 (v4)** | \\dpct-vfiler-01.dudley.local\users\sives\Desktop\The%20Dudley%20Group%20NHS%20Foundation%20Trust%20RGB%20BLUE_CROPPED%20CENTRAL.jpg |

***May we request that you do not highlight answers on the referral form as this does not show***

***when printed in black and white. Instead, please insert ‘x’, underline or delete as necessary.***

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| **CLIENT DETAILS** |
| Title |  | Forenames |  | Surname |  |
| **Is this a stroke referral?** Choose an item. **Date of Stroke:**  | **Is this an ESD referral?** Choose an item. | **Date of Discharge:** |

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| DOB  | Age  | Gender  | Marital Status widowed | NHS No.  |

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| --- | --- | --- | --- |
| Current Address |  | Permanent Address (if different) |  |
| Post Code |  | Post Code |  |
| Tel Number |  | Tel Number |  |
| Mobile |  |  |  |

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| Vulnerable Dependent |  | **Is there any known risk to staff visiting at home?** Choose an item. |

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| How is access gained to the home? |  |

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| **GP DETAILS** |
| GP Name |  | Practice Address Post Code |  |
| Practice Name |  |
| Tel Number |  | Courier No |  |

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| **CONSULTANT DETAILS** |
| Name  |  | Department & Hospital |  |

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| **NEXT OF KIN / CARER** |
| Name |  | Address |  |
| Relationship |  |
| Tel Number |  | Post Code |  |
| To be contacted to arrange appointments | Choose an item. | Emergency Contact | Choose an item. |

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| Main Spoken language | Choose an item. | Understands English | Choose an item. |
| Nationality |  | Ethnic Origin | Choose an item. |
| Religion |  | Interpreter required | Choose an item. |
| Communication Needs | Choose an item. (if yes please specify) |
| Advocate Required: Choose an item. | Asylum Seeker:Choose an item. | Alcohol or Drug Concerns: Choose an item. | Smoker: Choose an item. | Lives alone:Choose an item. |

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| **Current Medication (please attach script if available** |

Page 2

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| Patient Name |  | NHS No. |  |

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| **Does this patient have a DNACPR in place ? Yes/No** *(Delete as appropriate)*  |
| **Relevant Medical History / Diagnosis COVID Positive Test date**:  |
| Allergies: Choose an item. (if yes please specify) |
| **Current Presenting Problems / Reason for Referral**  |
| **Aim of Rehabilitation / Rehab Goal** Please refer to Social Services when requesting equipment only |
| Cognitive Assessment completed: MOCA /OCS /Other / N/A / None SCORE:…………….. Outcomes: |

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| **Mobility**  |
| Transfers independently [ ]  | With assistance of 1 [ ]   | With assistance of 2 [ ]  |
|  |
| Walking independently [ ]   | With assistance of 1 [ ]  | With assistance of 2 [ ]  |
|  |
| Walking aid used:  | Wheelchair self-propelled [ ]  | Attendant propelled [ ]  |
|  |
| Hoist [ ]  | Nursed in bed [ ]  |  |
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| Risk of falls: Choose an item. – if yes please provide detail |
| Is the patient aware of the referral and agreed to participation in active rehabilitation? Choose an item. |
| Other Services involved: Choose an item. – please specify LIT – Choose an item. New POC Choose an item. |

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| **REFERRER’S DETAILS** |
|  |  |  |  |  |  |
| Signature | Name printed | Designation | Location | Tel Number | Time/Date |

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| **Referrals accepted via Email as below:** |
| **Email**: dgft.drs@nhs.net | **Phone:** 01384 321600 Option 2 |

**ALL FIELDS ARE MANDATORY:** IF REFERRAL FORM IS NOT COMPLETED IN FULL, IT WILL BE RETURNED

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| **DRS STAFF USE ONLY DRS Triage Form**  |  |

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| **Patient Name:** **NHS No.**  | **Date Received** Click here to enter a date. |
| **Patient Tel No.-** **Patient Mobile-**  | Breach Date: Click here to enter a date.  |
| **Care Home** Choose an item. **Care Home Name:**  |
| **Existing or Previous referral details**: |
| **Warnings listed on OASIS:** |

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| **Existing Open Referral** Choose an item. **Existing Referral** **Date:**  |
| **DRS Contacts last 6 months** / 9 months for Neuro Choose an item. |

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| **Open Pathways:** ESD[ ]  Stroke[ ]  Rehab[ ]  Neuro[ ]  SLT Comm[ ]  DST[ ]  PD Ed [ ]  **Open to Clinicians**: PAP[ ]  PD Ed Session[ ]  Pharmacist[ ]  PD Nurse[ ]  MS Nurse[ ]  DST[ ]  Falls Nurse[ ]  Dietetics[ ]  OT HV[ ]  OT Clinic[ ]  Physio HV[ ]  Physio Clinic[ ]  SLT [ ]  TAP[ ]  |
| **Queries/Additional Info notes:** |

**TRIAGE**

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| **Triager-**  | **Triage Date** Click here to enter a date. |
| **Main Diagnosis – (OASIS)**Choose an item. | **Other Diagnosis – (WAITING LIST LOG) *(if Covid, please state type of entry for log i.e. long covid, covid/GP ref etc.)***  |

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| **Referral Reason: Rehab (056)** |
| **Referral Source:** Choose an item. |
| **Pathway:** Choose an item. |

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| Triage @ MDT [ ]  (pt already open to DRS) Choose an item. |

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| **Inappropriate Referral:** Choose an item. |
| **Duplicate Referral:** Choose an item.**Info only** Choose an item. |
| **Level of urgency: Stroke including Stroke SLT -** Choose an item. **SLT Comm / Rehab / Neuro**  - Choose an item.  |
| **Location:** Choose an item. **Postcode:** Choose an item. | **Rx Setting:** Choose an item. |

**Profession required:** Choose an item. **If band 4 - add profession:** Choose an item.

**Second profession required:** Choose an item. **Third profession required:** Choose an item.

**NEUROLOGY ONLY**

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| **Janine** [ ]  **Trudy** [ ]  Info Only [ ] To Action: Clinic Appt: Choose an item.  |

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| **Notes for Therapist by Triage:**  |

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| Clinician: | Date & Time of Appt:Click here to enter a date. | Stroke Log Completed [ ]  | Phone[ ]  Letter[ ]  Patient Informed[ ] Other informed name/relationship:  |