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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: |