**Please complete the below tick boxes for suitability of referral in line with inclusion criteria**

* **Patient has a confirmed neurological diagnosis**
* **Patient has active SMART Goals best met in an outpatient environment**

* **Patient is willing and able to engage with out-patient therapy**

* **If using hospital transport, patient must have an appropriate wheelchair with head rest, suitable access in and out of property e.g. ramps and can sit out in chair for minimum of 4hrs**

**Please be aware patients using hospital transport may be delayed and required to sit out for more than 4 hours**

* **We now only receive referrals from Derby City Area, please ensure the patient you would like to refer meets this criteria.**
* **Will patient be receiving therapeutic input from other services alongside this referral: Yes No**

**If yes, who: …………………………………………………………………………………**

By completing this form, you are asking for therapeutic input because you feel the individual would benefit from either, continuing care in an outpatient capacity or they have been highlighted to need new assessments in an outpatient setting. **Our capacity to provide home visits is extremely limited.**

PLEASE INCLUDE COPIES OF ANY RELEVANT ASSESSMENTS / REPORTS

Please return to:

[dhft.SpecialistRehabilitation@nhs.net](mailto:dhft.SpecialistRehabilitation@nhs.net)

For any further information:

Tel: 01332 258255

**Please complete all mandatory fields marked with a \*. Failure to complete these fields will result in referrals not being accepted.**

**\*Referral for:**

**PHYSIOTHERAPY**

**OCCUPATIONAL THERAPY**

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Hosp No:** |  | **\*NHS No:** |  |
| **\*Title:** | Mr | **\*Date of Birth:** |  |
| **\*Forename:** |  | **\*Surname:** |  |
| **\*Tel Home:** |  | **\*Tel Mobile:** |  |
| **\*Address:** |  | **Email:** | **Able to use internet?**  **Yes**  **No** |
| **\*NOK Name and Relationship to patient:** |  | **\*NOK Tel No:** |  |
| **\*Interpreter:** | Yes  No  **\*Language:** | | |
| **\*GP Address and Telephone number:** |  | **Consultant:** |  |
| **\*Transport to/from NOTS:** | Patient will be using ambulance transport  Yes:No: | **\*Moving and Handling needs:** | Independent  Assistance of 1  Assistance of 2  Other: ………………… |
| **\*Safety concern i.e., mood, specialist equipment:** |  | **\*Allergies:** | Yes ………………….  No |
| **\*Swallowing difficulties:** | Yes …………………  No |

|  |  |
| --- | --- |
| **\*Consent to leave an answer phone message?** | Yes  No |
| **\*Consent to leave a phone message with NOK?** | Yes  No |

|  |  |
| --- | --- |
| **\*Diagnosis-**  i.e. when diagnosed, is patient aware of diagnosis |  |
| Recent investigations- |  |
| **\*PMH-** |  |
| **Social circumstances-** | |
| Lives with: |  |
| Adaptations: |  |
| Package of care:  i.e. carers or assistance needed for ADL’s | Agency:  Phone number: |
| **Work-** | |
| Employment Status: | Self employed Returned to work  Receiving statutory sick pay  Date due to stop \_\_/\_\_\_/\_\_\_\_ |
| Job Role | Traffic enforcement officer |
| Has a referral to Occupational Health been completed? | Yes  No |
| Has patient been advised about benefits? | Yes  No |
| **Cognition-** | |
| **\*Any concerns regarding cognition:** | Yes ……………………………………………………  No |
| Cognitive assessments, scores and datescompleted: |  |
| **Physical-** | |
| **\*Current mobility:** |  |
| Stairs: |  |
| Outdoor mobility: |  |
| Upper limb:  i.e., range of movement, pain, sensory changes, splints worn |  |
| Lower limb:  i.e. Range of movement, pain, sensory changes, splints worn |  |
| Outcome Measures  scores and dates completed: |  |
| **Falls history (\*if applicable)-**  **N/A** | |
| Nature: |  |
| Frequency: |  |
| Previous interventions: |  |
| **Speech-**  **N/A** | |
| **\*Aphasic:** | Yes  **Type if known:…………………..**  No |
| Strategies to assist understanding: |  |

|  |  |  |
| --- | --- | --- |
| Other professionals involved: | | |
| Name: | Role: | Contact details: |
|  |  |  |

|  |
| --- |
| **\*On-going rehabilitation goals as discussed with the patient-**  (Please ensure these are goals to be attained within the outpatient service)  1  2  3 |

PLEASE INCLUDE COPIES OF ANY RELEVANT ASSESSMENTS / REPORTS

|  |  |
| --- | --- |
| **\*Name of referrer:** |  |
| **\*Profession:** |  |
| **\*Contact details (email and telephone number):** |  |
| **\*Date of referral:** |  |

Please return to:

[dhft.SpecialistRehabilitation@nhs.net](mailto:dhft.SpecialistRehabilitation@nhs.net)

For any further information:

Tel: 01332 258255