

**Neuro-Rehabilitation Referral/Assessment Form**

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| **Referrer name:****Hospital number:****DOA:****(date of admission)** | **Contact detail:** |
| **Patient information:** **(*insert patient ID or label)******NHS No:*****Surname:****First name:****Date of birth:** **Address:** | **Next of kin:****Current location:****Responsible consultant:****GP:****Ethnicity:** |
| **Diagnosis:** |
| **Clinical history:** |
| **Result of relevant investigation:** |
| **Summary of treatment and interventions to date:** |
| **Medication and Allergies:** |
| **Progress, management and complications:** |
| **Planned future treatment/hospital appointments:** |
| ☐None | ☐Further surgery | ☐Radiotherapy  | ☐Chemotherapy  | ☐Other (specify) |
| **Pre-illness information:** |
| Significant medical history: |  |
| Family support |  | Work |  |
| Housing |  | Leisure |  |
| **Infection screening:** |
| MRSA | ☐Yes | ☐No | Date screened |
| C.Diff | ☐Yes | ☐No | Date screened |
| MDR Acinetobacter | ☐Yes | ☐No | Date screened |
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| **COVID Status**  |
| COVID Positive:  Yes☐                 No☐        Unknown ☐Date of result: | Symptoms:Date of onset: |

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| **Supplementary Data****Functional status and intervention** | ***Insert patient ID or Label*** |
| **Tick all that apply** | **Detail and Plan** |
| **Neurological/Locomotor** | GCS:E---V---M--- Total:-----☐Motor loss☐Sensory loss/hypersensitivity☐Visual impairment☐Hearing impairment☐Increased tone☐Decreased tone☐Contracture☐Pain☐Other musculoskeletal problem ☐Splinting/orthotics required  |  |
| **Respiratory** | ☐Self-ventilating☐Assisted ventilation: type? ----☐Tracheotomy☐ET tube ☐Oxygen therapy ☐Weaning plan/management plan☐Chest physiotherapy /suction |  |
| **Mobility and transfers** | ☐Nursed in bed☐Independent sitting balance☐Wheelchair/special seating☐Walks independently☐Unable to walk☐Walks with help of ---persons☐Walks with supervision only☐Walks with an aid-----☐Transfers independently☐Transfers with help of ---persons☐Transfers with an aid ------  |  |
| **Continence** | ☐Continent-independent☐Continent-assistance of ---persons☐Urinary incontinence☐Catheter/pads/convene☐Urine retention☐Faecal incontinence☐Constipation☐Bowel regime |  |
| **Skin** | ☐Pressure sore risk score☐Pressure sore/s identified☐Grade-----location-----☐Grade -----location-----☐Grade -----location-----☐Other wounds☐Tissue viability nurse required☐Special mattress /cushion |  |
| **Supplementary Data****Functional status and intervention** | *insert patient ID or Label* |
| **Tick all that apply** | **Detail and Plan** |
| **Communication** | ☐Not impaired ☐Impaired☐Expressive dysphasia☐Receptive dysphasia☐Communication aids used☐Type of aids----☐SLT required☐Dysarthria☐Other communication deficits |  |
| **Nutrition and Hydration Status** | ☐Swallowing not impaired☐Swallowing impaired☐Nil by mouth☐Modified diet-type---☐Modified fluids-type---☐Independent with/without aids☐Requires prompting/supervision only☐Require assistant of ----persons☐Fed via NGT/PEG/PEJ/TPN☐Dietitian required☐SLT required  |  |
| **Washing and Dressing** | ☐Independent☐Groom self☐Requires prompts/supervision only☐Requires assistance of ----persons☐Unable to participate in any way |  |
| **Cognitive/Psychosocial** | ☐Sensory(vision/hearing)☐Cognitive /perceptual☐Behavioural management☐Mood/emotional management☐Safety awareness management☐Require close supervision☐Require 1:1 supervision☐Formal family support☐Psychology required☐Psychiatry required☐Consent or capacity consideration☐Post traumatic amnesia (PTA) present? |  |
| **Discharge Planning** | ☐Housing/placement☐Environmental/home visit☐Equipment/home adaptations☐Community support☐Vocational /educational services☐Benefits/finances ☐Social services required |  |
| **Name:** | **Designation:** |
| **Signed:** | **Date:** |
| Form to be emailed to referrals.specialistrehabilitation@nhs.netFor further information, please contact Sr Catherine Dowling Admissions and Discharge Co-ordinator on 0121 466 6594. |