

**Neuro-Rehabilitation Referral/Assessment Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |
|  | |  | |  | |  | |

|  |  |
| --- | --- |
| **COVID Status** | |
| COVID Positive:  Yes☐                 No☐         Unknown ☐  Date of result: | Symptoms:  Date of onset: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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.net](mailto:referrals.specialistrehabilitation@nhs.net)  For further information, please contact Sr Catherine Dowling Admissions and Discharge Co-ordinator on 0121 466 6594. | | | | |