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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Neurology rehab referral form** | | | | | | | | | | | | | | | | | | | | | | |
| Ward:  Ward covid status: | | Admission date: | | | | | | Date/Time referral made: | | | | | | | | | | | | | | |
| Patient’s address |  | | | | | | | | | | | | | | | | | | | | | |
| NOK Name |  | | | | | NOK telephone | | | | | | |  | | | | | | | | | |
| GP Name |  | | | | | GP Practice | | | | | | |  | | | | | | | | | |
| **COVID** | Status:  Date of screen: | | | | | NEWS 2: | | | | | | | Date/Time: | | | | | | | | | |
| **Named consultant for neurological condition:** |  | | | | | In case of neurological deterioration: | | | | | | | Transfer back to the Acute  Palliation  Discussed with patient and relative: Y/N | | | | | | | | | |
| ReSPECT / Resus status |  | | | | | Respiratory function:  O2 required? Suctioning required? | | | | | | | |  | | | | | | | | |
| Reason for admission  Diagnosis/plan  Allergies |  | | | | | | | | | | | | | | | | | | | | | |
| Relevant imaging report, confirming diagnosis: |  | | | | | | | | | | | | | | | | | | | | | |
| Planned future treatment: | ☐None | | | | ☐Further surgery | | ☐Radiotherapy | | | | | | | | ☐Chemotherapy | | | | | ☐Other (specify) | | |
| Has the diagnosis and prognosis been discussed with the patient and relative? | Y / N | | | | | | | | | | | | | | | | | | | | | |
| Name of family members present for discussion: |  | | | | | | | | | | | | | | | | | | | | | |
| Summary of discussion with the patient and family? Inc prognosis & any written information |  | | | | | | | | | | | | | | | | | | | | | |
| Patients expectation of transfer to Evesham: | Active rehab Period of assessment Discharge planning | | | | | | | | | | | | | | | | | | | | | |
| Has discharge planning been discussed or commenced: | Y / N | | | | | | | | | | | | | | | | | | | | | |
| Cognitive Function /impairment / behaviour:  Cognitive assessments – Outcome/Score)  In Patient complications  (i.e. Falls/DoLs/1:1) |  | | | | | **Position on Ward** | | | | | | | | | | | | | | | | |
| General | | | | | | | | | | | | Enhanced within arm’s reach | | | | |
| Intermittent | | | | | | | | | | | | In side room \* why? detail below | | | | |
| Constant within eyesight | | | | | | | | | | | | Rockwood score | | | | |
| Past Medical History |  | | | | | | | | | | | | | | | | | | | | | |
| Nutrition modified diet / NG/ PEG SALT recommendations) |  | | | | | | | | | | | | | | | | | | | | | |
| Communication impairment: |  | | | | | | | | | | | | | | | | | | | | | |
| Pain:  Management plan: | Y/N | | | | | | | | | | | | | | | | | | | | | |
| Pre Hospital Function, Home circumstances |  | | | | | | | | | | | | | | | | | | | | | |
| PLEASE SEND THROUGH INITIAL AND CURRENT NEUROLOGICAL ASSESSMENT  (PHOTOCOPY OF PAPERNOTES ACCEPTABLE) | | | | | | | | | | | | | | | | | | | | | |
| Mobility and any therapy instructions / specialist equipment  Inc. Specialist seating / sitting balance / sitting tolerance) |  | | | | | | | | | |  | | | | | | | | | | | |
| Splinting / orthotics:  Type & regime: | Y/N | | | | | | | | | |  | | | | | | | | | | | |
| Goals achieved: |  | | | | | | | | | |  | | | | | | | | | | | |
| Ongoing SMART goals: |  | | | | | | | | | |  | | | | | | | | | | | |
| Admission outcome measure score: |  | | | | | | | | | |  | | | | | | | | | | | |
| Current outcome measure score: |
| Specialist meds/Any Antibiotics? |  | | | | | | | | | | | | | | | | | | | | | |
| Infection Prevention & Control concerns | YES |  | | Details | | | | | | | | | | | | | | | | | | |
| NO |  | |
| Medical Plan - including plans around deranged bloods | | | | | | | | | | Bloods/date | | | | | | |  | | Bloods/date | |  | |
|  | | | | | | | | | | Hb | | | | | | |  | | CRP | |  | |
| WCC | | | | | | |  | | Na+ | |  | |
| Urea | | | | | | |  | | K+ | |  | |
| Creat | | | | | | |  | |  | |  | |
| Pressure Areas/ Waterlow/Tissue Viability |  | | | | | | | | | | | | | | | | | | | | | |
| Catheter Y/N  Type/ date inserted |  | | | | | TWOC Considered Y/N | | | | | | | | | |  | | | | | | |
| Bowels last open | Date | |  | | | Type | | |  | | | | | | | | | | | | | |
| Any other relevant information: |  | | | | | | | | | | | | | | | | | | | | | |
| Has post discharge follow up appointment been arranged: | Y / N:  If yes, Time / date & with who:  If no, please arrange prior to transfer | | | | | | | | | | | | | | | | | | | | | |
| Recommended Pathway: eg PW2 – rehab / PW3 (DTA) |  | | | | | | | | | | | | | | | | | | | | | |
| Completed By :  Name and designation |  | | | | | Sent to : hospital ward | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | |