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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 AcutePalliationDiscussed with patient and relative: Y/N |
| ReSPECT / Resus status |  | Respiratory function: O2 required? Suctioning required? |  |
| Reason for admissionDiagnosis/planAllergies |  |
| 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 |  |
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