MAJOR TRAUMA – REHABILITATION PRESCRIPTION V4
Core Information

Date Commenced:	**Time Commenced:**		**Commenced By:**
Key Worker Name:		**Contact Details:**	
NHS no:		**Date of Injury:**	
Insert label or: Surname: First name: Date of birth: Address: GP:		**Current location:** **MTC:**	
The TARN minimum dataset (this section MUST be completed)			
Rehabilitation prescription (completed or not required)		**□ No**	**□ Yes** **□ Not required**
Presence of physical factors affecting activities or participation		**□ No**	**□ Yes** **□ Not assessed**
Presence of cognitive/mood factors affecting activities or participation		**□ No**	**□ Yes** **□ Not assessed**
Presence of psychosocial factors affecting activities or participation		**□ No**	**□ Yes** **□ Not assessed**
Initial GCS: **Clinical History and List of all Injuries:**			
Estimated ISS:		**Barthel Score_____ OR NPDS Score _____**	
Summary of Interventions to date:			
Progress, management and complications:			
Pre-injury/illness information			
Significant medical history			
Family support		Work	
Housing		Leisure	
Name: Designation:		Signed:	Date:

Insert patient ID or label

Summary

Rehabilitation Goals *(including predicted time frame)*

Key management plan: *(e.g. procedures / reviews awaited, advice re: weight bearing status, use of orthoses)*

Services referred to:*(including contact details and anticipated waiting time)*

Other key information: *(e.g. patient/family wishes, potential discharge barriers, immigration/residency)*

Rehabilitation Complexity Scale Extended (RCS-E) Trauma version

	0	1	2	3	4	5	6
Medical	None active	Basic	Specialist	Potentially unstable	Acute medical/surgical	TU	MTC
Care	Independent	1 carer	2 carers	≥ 3 carers	1:1 supervision		
Risk	None	Low	Medium	High	Very high		
Nursing	None	Qualified	Rehab nurse	Specialist nursing	High dependency		
Therapy disciplines	None	1	2-3	4-5	≥ 6		
Therapy Intensity (Total therapist time)	None	low level (< daily) <15 hrs/wk	Moderate (eg daily) 15-24 hrs/wk	High (+ assistant) 25-30 hrs/wk	Very high >30 hrs/wk		
Equipment	None	Basic	Specialist	Specialist - trauma	-		

RCSE: M_____ C / R (whichever highest)_____ N_____ Td_____ Ti_____ E_____ Total_____/25

Name: Designation: Signed: Date:

Patient / carer has received copy of Rehabilitation Prescription? Yes □ No □

If not shared with patient/carer, reason withheld: ……

This rehabilitation prescription is prepared on the basis of assessments made to date and is subject to modification following further assessment by future service providers however it provides no guarantee of service availability.

Insert patient ID or label

Supplementary Data

Functional Status and Intervention Required:

	Tick all that apply	Details 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? _____ ☐ Tracheostomy ☐ ET tube ☐ Oxygen therapy ☐ Weaning plan/management plan ☐ Chest physiotherapy/suction	
Mobility & 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/conveen ☐ Urine retention ☐ Faecal incontinence ☐ Constipation ☐ Bowel regime	
Skin	☐ Pressure sore risk score _____ (type of scoring used _____) ☐ Pressure sore/s identified ☐ Grade _____ location _____ ☐ Grade _____ location _____ ☐ Grade _____ location _____ ☐ Other wounds ☐ Treatment plan documented ☐ Tissue viability nurse required ☐ Special mattress/cushion	

Name: Designation: Signed: Date:

Insert patient ID or label

Functional Status and Intervention Continued:

Communication	□ Not impaired □ Impaired □ Expressive dysphasia □ Receptive dysphasia □ Communication aids used □ Type of aid _____ □ SLT required □ Dysarthria □ Other communication deficits	
Nutrition & Hydration Status	□ Swallowing not impaired □ Swallowing impaired □ Nil by mouth □ Modified diet – type _____ □ Modified fluids – type _____ □ Independent with/without aids □ Requires prompting/supervision only □ Requires assistance of_____ persons □ Fed via NGT/PEG/PEJ/TPN □ Dietitian required □ SLT required	
Washing & Dressing	□ Independent □ Grooms 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 □ Requires close supervision □ Requires 1:1 supervision □ Formal family support □ Psychology required □ Psychiatry required □ Consent or Capacity considerations □ 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:

Sign-off by Consultant in Rehabilitation Medicine:_____

Name: Signed: Date:

Appendix 1

Insert patient ID or label

Injury Management: Detailed Information

Injury	Consultant/Team	Management plan	Review Date	Actions required

Appendix 2

Clinicians involved in this prescription:

Name	Role	Contact details