**Neuro-Rehabilitation Referral/Assessment Form**

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| **Reviewed by Rehab Consultant Y/N**  **Name:**  **Recommended level 1/2a 2b**  **PCAT score on referral:** | | | | | | **Patient information: (*insert patient ID or label)***  **NHSNo*:***  **Surname:**  **First name:**  **Date of birth:**  **Address:**  **GP:**  **Ethnicity:**  **Nationality:** | | | | |
| **Current Hospital and ward:**  **Responsible consultant:** | | | | | |
| **Referrer name:**  **Tel no:**  **E-mail:** | | | | | | **Next of kin name:**  **Relationship to patient:**  **NoK contact details:** | | | | |
| **Diagnosis:** | | | | | | | | | | |
| **Clinical history:** | | | | | | | | | | |
| **Result of relevant investigation:** | | | | | | | | | | |
| **Summary of treatment and interventions to date:** | | | | | | | | | | |
| **Medication and allergies, including food 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 19  Date of result | | | Positive  Symptoms: | | | Negative | | | Unknown | |
| **Functional status and intervention** | | **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 | | | | | | NB CERU does not accept referrals for patients who have a trache and NGT in situ | | |
| **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 ------  Bariatric equipment required? Y/N | | | | | |  | | |
| **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 | | | | | |  | | |
| **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 (specify which)  ☐Dietitian required  ☐SLT required | | | | | | \*If NGT in situ please complete section 2 at end of form  Current weight =  Current BMI = | | |
| **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 [swg-tr.ceru-referrals@nhs.net](mailto:swg-tr.ceru-referrals@nhs.net)  For further information, please contact the Patient Flow Team on 01926 317700 ext 7725, 7576 or 7776 | | | | | | | | | | |