## East-Midlands Regional Rehabilitation Referral Form

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| Referring Unit / Ward | Referring speciality | Referring Team |
| C30 | Click here to enter text. | *Name & designation*Click here to enter text. |

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| Demographics |
| Patient Name | Address | DOB | NHS Number |
|  | Click here to enter text.OtherIf other pls specifiy in address above | Click here to enter a date. | Click here to enter text. |
| Next of Kin | Relationship | Contact Number |
|  |   | Click here to enter text. |
| Patients GP | GP address | GP postcode |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

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| **Current inpatient details** |
| Current Hospital | Click here to enter text. |
| Current ward  |  | Tel no: Click here to enter text. |
| Date of admission  | Click here to enter text. |
| Main Diagnosis | Choose an item.If other, pls specify: Click here to enter text. |
| History of presenting complaint / mechanism of injuryDate of Injury |  |

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| Reason for rehab referral (please be specific as to why this patient needs rehab) |  |

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| **Injury / medical problem** | **Intervention** | **Date** | **Weight bearing / splints/ braces etc. inc duration** | **Follow up required** |
|  |  | Click here to enter a date. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. |  |  | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. |  | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. | Click here to enter text. |
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| Consultants & Specialities involved in patients care | Click here to enter text. |
| If the patient is an oncology patient, what is prognosis and ongoing plan? | Click here to enter text. |
| Investigations outstanding |  |
| PMH: | Click here to enter text. |
| NKDA [ ]  Allergies:  | Click here to enter text. |
| Relevant medication and indications: | *(Anti-epileptics? Anti-thrombotics? Steroids?sedatives? vasopressors?)*Click here to enter text. |
| Is the patient for resuscitation? Y [ ]  N [ ]  |

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| Current GCS | GCS on admission |  |
| E V M  | E V M  | Patient’s lowest GCS recorded: How long did this period last?  | If the patient has been in an induced coma, please specifiy how long for. Click here to enter text. |

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| How does the patient communicate?  |
| Language spoken:  |

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| Oxygen |  |
| Tracheostomy Y [ ]  N [ ]  Type: Click here to enter text.  | Size:  |
| Cuffed [ ]  Un-cuffed [ ]  Occluded [ ]  | Weaning Y [ ]  N [ ]  Hours: Click here to enter text. |
| Oxygen Y [ ]  N [ ]  %: Click here to enter text. |

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| Current infections Y [ ]  N [ ]  Please state infection: Click here to enter text. |
| Barrier nursed Y [ ]  N [ ]  If yes, reason: Click here to enter text. |
| Pressure areas intact Y [ ]  N [ ]  | Location of wound: Left elbow | Grade: 2Specialist mattress required? Y [ ]  N [ ]  |
| Does the patient have a moisture lesion? Y [ ]  N [ ]  | Location of wound: Click here to enter text. |  |
| Any traumatic or surgical wounds Y [ ]  N [ ]  | Details: Occipital laceration  | Date of removal of clips/sutures |
| Does the patient need a pain management plan? Y [ ]  N [ ]  | Details: Click here to enter text. |  |

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| Bladder & Bowel |

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| Is the patient continent Y [ ]  N [ ]  |
| Urinary catheter in situ Y [ ]  N [ ]  Date inserted: Long / short term? Removal plan:  |
| Frequency of bowel opening:  |
| Independent with voiding & elimination? Y [ ]  N [ ]  |

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| Swallowing |
| Independent [ ]  PEG [ ]  NG Tube [ ]  |
| Current SALT recommendations:  |

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| **Functional Ability** |
| Washing: |   |
| Dressing upper body: |   |
| Dressing lower body: |   |
| Transfers: |  Aid: l Hoist [ ]   |
| Mobility: |  |
| Wheelchair  | Y [ ]  N [ ]  Independent [ ]  Attendant operated [ ]  |
| Seating Regime needed? | Y [ ]  N [ ]  What seat?  How long sat out / 24hrs? Click here to enter text. |
| Any Splinting needed? | Y [ ]  N [ ]  Where / on/off periods / duration? Click here to enter text. |
| Falls risk info |   |

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| Previous Ability |  | Additional Info |
| Living independently | Y [ ]  N [ ]  | Accommodation type/ shared with:  |
| Employment status | Y [ ]  N [ ]  | Job: Click here to enter text. |
| Mobility |   |  |
| Social service involvement | Y [ ]  N [ ]  | Details: Click here to enter text. |
| Patient Baseline info |  |

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| Anticipated rehab destination: |   |
| Any additional info: |   |