## 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.  Other  If 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 injury  Date 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: 2  Specialist 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: |  |