**Worcestershire Integrated Neurological and Rehabilitation Service**

**Referral Form**

***Please ensure this form is complete and accurate.***

***Please note we are not a rapid response service and must not be considered when preparing a discharge plan from hospital or for patients requiring urgent treatment.***

If you answer no to any of these questions, the patient will not be accepted by our service.

Does this patient have:

* A Worcestershire GP?
* A neurological diagnosis with the cause of their current symptoms being neurological in nature?
* Specialist needsthat are not being met or able to be met by other existing services?

**Patient Details**

|  |  |
| --- | --- |
| **Has the patient consented to this referral?** Yes □ No □  **If the patient does not have capacity to do this, do you deem this referral is in their best interest?** Yes □ No □ | |
| **Surname:** | **Title: Mr□ Mrs□ Ms□ Miss□ Other□** |
| **Forename(s):** | **NHS No:** |
| **Address:**  **Postcode:** | **Date of birth:** |
| **Next of kin:**  **Relationship:**  **Telephone No:** |
| **Telephone Number:** |
| **Email address:** | ReSPECT Form in place? Yes □ No □ |
| **GP Surgery:** | **GP Telephone No:** |
| **Accommodation Type:** | **Employment status:** |

**Referrer Details**

|  |  |
| --- | --- |
| **Name**: | **Job Title:** |
| **Phone No:** | **Email Address:** |

**Patient Information**

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| **Patient’s Diagnosis:** | |
| **Is the patient under the care of a consultant?** Yes □ No □  **If so, name, location and contact details:** | |
| **Has the patient had previous interventions for this condition?** Yes □ No □  **If yes, please give details:** | |
| **Does the patient have involvement with or been referred to any other service?** Yes □ No □  **If yes, please give details:** | |
| **Has the patient had a hospital stay within the last 12 months?** Yes □ No □  **If yes, please give details:** | |
| **Interpreter required?** Yes □ No □  If yes, what language?  **Does this patient have any communication Problems** Yes □ No □  **If yes, what strategies are used to communicate effectively with the patient?** | |
| **Does this patient have any communication or information support needs, e.g. do they need information in easy read, braille or large print** Yes □ No □  If Yes, please give details: | |
| **Is the patient able to travel to a clinic appointment?** Yes □ No □ | |
| **Are there any potential risks for a home visit or any issues to highlight before we arrange an initial assessment?** E.g.Behaviour – client, carers etc, history of verbal / physical aggression?, Substance misuse? Mental health problems that might cause inappropriate / challenging behaviour? Are there any safeguarding issues or DOLS issues? | |
| **Support required from Integrated Neurological and Rehabilitation Service**  **(please tick all that apply)** |

|  |  |  |
| --- | --- | --- |
| Neurological Therapy Team Occupational Therapist □ Physiotherapist □ | Specialist Neuro Nursing □ | Spasticity management □ |
| Parkinson’s Disease  Nurses □ | Acquired Brain Injury Occupational Therapist □ | Neuro review clinic □ |
| Epilepsy specialist Nurses □ | Acquired Brain Injury Speech & LanguageTherapist □ | Multiple Sclerosis nurses □ |

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| **Please state patient’s goals and requirements for intervention** | |
| **Problem** | **Patient Goals** |
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