REFERRAL FOR AQUIRED BRAIN INJURY/ SPINAL INJURY/ STOKE OUT OF AREA REHABILITATION/TREATMENTS.

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| **Date of referral : Rehabilitation level:** | |
| **Name: Location of patient:**  **NHS No:**  **DOB:**  **Home Address**: | |
| **Name of GP and practice:** | **Name, number and designation of lead referrer:** |
| **Name and number of consultant:** | **Name and number of psychologist:** |
| **Name, address and phone number of next of kin:**  Next of kin aware of referral – Yes – No  Patient aware of referral – Yes - No | |
| **Reason for referral**. Giving a summary of current needs, diagnosis and assessment. Including the status of level according to the Specialised Neurorehabilitation services standards | |
| **Type of intervention required and why need cannot be met by local services:** | |
| **Suggestions of appropriate rehab units if able.** | |
| **List of current medications.** | |
| **Family and social context.** | |
| 1. **Behaviour**   **Summary of need.**  **Recommended need/therapy goals/ actions .** | |
| 1. **Cognition.**   **Summary of need.**  **Recommended need/therapy goals/ actions .**   1. **psychological and emotional.**   **Summary of need.**  **Recommended need/therapy goals/ actions .** | |
| 1. **Communication**   **Summary of need.**  **Recommended need/therapy goals/ actions .**     1. **Mobility.**   **Summary of need.**  **Recommended need/therapy goals/ actions .**  **Equipment needed/ training required.** | |
| 1. **Continence.**   **Summary of need.**  **Recommended need/therapy goals/ actions .** | |
| 1. **Nutrition.**   **Assessment of need.**  **Recommended need/therapy goals/ actions .**  **Equipment needed/ training required.** | |
| 1. **Tissue viability**   **Summary of need.**  **Recommended need/therapy goals/ actions .** | |
| 1. **Breathing**   **Summary of need.**  .  **Recommended need/therapy goals/ actions .**  **Equipment needed/training required.** | |
| 1. **Drug therapies and medication.**   **Summary of need.**  **Recommended need/therapy goals/ actions .** | |
| 1. **Altered states of consciousness.**   **Summary of need.**  **Recommended need/therapy goals/ actions .** | |
| **Additional information** | |
| **Names of Team referring** | **Sign** |