**Before you submit your referral, please ring 020 3311 1948 to discuss your patient with the team. The administrator will help you submit this form following this discussion.**

**CHARING CROSS NEURO-REHABILITATION UNIT REFERAL FORM**

|  |  |
| --- | --- |
| NHS No: | Hospital No: |
| Family Name: | Forename: |

**BASIC PERSONAL INFORMATION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: |  | Forename: | |  | | Family Name: | | |  |
| Preferred Name: | |  | | | | | | | |
| Date of Birth: | |  | | | | | | | |
| Gender: | |  | | | | | | | |
| Permanent  Address: | |  | | Borough: | | | |  | |
| Postcode: | |  | | | | | | | |
| Home Tel: | |  | | | | | | | |
| Mobile No: | |  | | | | | | | |
| GP details: | |  | | GP Tel No: | | | |  | |
| Current Location: | |  | | | | | | | |
| Tel: | |  | | | | | | | |
| Ethnicity: | |  | | | | | | | |
| Religion: | |  | | | | | | | |
| Next of Kin: | |  | Relationship: | |  | | Tel: | |  |
| Main  contact/carer  (if different): | |  | Relationship: | |  | | Tel: | |  |
| Access details  (Key safe/lift/stairs, etc.): | | | | |  | | | | |
| Risk factors for home visit: | | | | |  | | | | |
| 2 person visit required? | | | | |  | | | | |

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| --- | --- | --- | --- |
| **Contact Details:** | | | |
| Consultant: |  | Psychologist: |  |
| Contact Details: |  | Contact Details: |  |
| Occupational  Therapist: |  | Physiotherapist: |  |
| Contact Details: |  | Contact Details: |  |
| Dietician: |  | Speech & Language  Therapist: |  |
| Contact Details: |  | Contact Details: |  |

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| --- | --- |
| NHS No: | Hospital No: |
| Family Name: | Forename: |

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| Referral to: OT - PT - SLT - Dietician - Psychologist - | | | | | | | | | | | | | | | | | | |
| Consent to referral: Patient - Unable to consent: - N.O.K informed: - | | | | | | | | | | | | | | | | | | |
| **MEDICAL INFORMATION** | | | | | | | | | | | | | | | | | | |
| Diagnosis:  (for Stroke please specify  date/ type/ location) | | | | |  | | | | | | | | | | | | | |
| Date of admission to  hospital | | | | |  | | | | | | | | | | | | | |
| Co-morbidities/PMH: | | | | |  | | | | | | | | | | | | | |
| Current medications | | | | |  | | | | | | | | | | | | | |
| Dosette box: | | | | |  | | | | | | | | | | | | | |
| **SOCIAL INFORMATION** | | | | | | | | | | | | | | | | | | |
| Pre-admission social  history and functional level | | | | | | | | | | | | |  | | | | | |
| Previous care package: | | | | | | | | | | | | |  | | | | | |
| Employment prior to  admission: | | | | | | | | | | | | |  | | | | | |
| **CONTINENCE AND SKIN CARE** | | | | | | | | | | | | | | | | | | |
| Urine: | |  | | | | | | | | Management plan: | | | |  | | | | |
| Faeces: | |  | | | | | | | | Management plan: | | | |  | | | | |
| Any pressure areas of concern? | | | | | | | | | |  | | | | | | | | |
| Recommendations: | | | | | | | | | |  | | | | | | | | |
| **NUTRITION** | | | | | | | | | | | | | | | | | | |
| Weight: |  | | | | | Height: | | |  | | | | | | BMI: | |  | |
| Dysphagia: |  | | | | | | | | | | | | | | | | | |
| Food consistency: | | | |  | | | | | | | | Fluid consistency: | | | |  | | |
| Diet type: | | | |  | | | | | | | | Route: | | | |  | | |
| Supplements: | | | |  | | | | | | | | | | | | | | |
| **COMMUNICATION** | | | | | | | | | | | | | | | | | | |
| Hearing: |  | | | | | | Preferred  language: |  | | | | | | | Is an interpreter  required?: | | |  |
| Dysarthria: |  | | | | | | | | | | | | | | | | | |
| Dysphasia: | | | Expressive: | | | | |  | | | | | Receptive: | | |  | | |
| Cognitive communication disorder: | | | | | | | |  | | | | | | | | | | |
| **PERSONAL CARE** | | | | | | | | | | | | | | | | | | |
| Method: |  | | | | | | | | | | | | | | | | | |
| Assistance: |  | | | | | | | | | | | | | | | | | |
| **MOBILITY** | | | | | | | | | | | | | | | | | | |
| Seating  requirements: | | | | | | | | | | |  | | | | | | | |
| Wheelchair referral  completed? | | | | | | | | | | |  | | | | | | | |
| Transfer Method: | | | | | | | | | | |  | | | | | | | |
| NHS No: | | | | | | | | | | | Hospital No: | | | | | | | |
| Family Name: | | | | | | | | | | | Forename: | | | | | | | |

|  |  |
| --- | --- |
| Mobility: |  |

|  |  |
| --- | --- |
| **PSYCHOLOGICAL FUNCTION** | |
| Mood: |  |
| Cognition: |  |
| Behaviour: |  |
| Other: |  |
| **VISION** | |
|  | |
| **SPASTICITY/PAIN** | |
|  | |
| **UPPER LIMB FUNCTION** | |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Centred MDT Goals | | | |
|  | On Admission  Date : | Current  Date : | Goals |
| Impairments |  |  |  |
| Activities |  |  |
| Participation |  |  |

Outcome measures/ standardised assessments completed

|  |  |
| --- | --- |
| Date: |  |

|  |  |
| --- | --- |
| Additional information: |  |

**DISCHARGE**

|  |  |  |  |
| --- | --- | --- | --- |
| EDD: | |  | |
| Environmental recommendations | |  | |
| Equipment provided/ required: | |  | |
| Package of care: | |  | |
| Social worker: |  | Tel: |  |
| Other referrals (e.g. district nurse): | |  | |
| Signed: |  | Print Name: |  |
| Agency: |  | Date: |  |

Cc:

GP Patient Community Team Social Worker Medical Notes Therapy Notes