**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: |  |
| PermanentAddress: |  | Borough: |  |
| Postcode: |  |
| Home Tel: |  |
| Mobile No: |  |
| GP details: |  | GP Tel No: |  |
| Current Location: |  |
| Tel: |  |
| Ethnicity: |  |
| Religion: |  |
| Next of Kin: |  | Relationship: |  | Tel: |  |
| Maincontact/carer(if different): |  | Relationship: |  | Tel: |  |
| Access details(Key safe/lift/stairs, etc.): |  |
| Risk factors for home visit: |  |
| 2 person visit required? |  |

|  |
| --- |
| **Contact Details:** |
| Consultant: |  | Psychologist: |  |
| Contact Details: |  | Contact Details: |  |
| OccupationalTherapist: |  | Physiotherapist: |  |
| Contact Details: |  | Contact Details: |  |
| Dietician: |  | Speech & LanguageTherapist: |  |
| Contact Details: |  | Contact Details: |  |

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

|  |
| --- |
| Referral to: OT - PT - SLT - Dietician - Psychologist - |
| Consent to referral: Patient - Unable to consent: - N.O.K informed: - |
| **MEDICAL INFORMATION** |
| Diagnosis:(for Stroke please specifydate/ type/ location) |  |
| Date of admission tohospital |  |
| Co-morbidities/PMH: |  |
| Current medications |  |
| Dosette box: |  |
| **SOCIAL INFORMATION** |
| Pre-admission socialhistory and functional level |  |
| Previous care package: |  |
| Employment prior toadmission: |  |
| **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: |  | Preferredlanguage: |  | Is an interpreterrequired?: |  |
| Dysarthria: |  |
| Dysphasia: | Expressive: |  | Receptive: |  |
| Cognitive communication disorder: |  |
| **PERSONAL CARE** |
| Method: |  |
| Assistance: |  |
| **MOBILITY** |
| Seatingrequirements: |  |
| Wheelchair referralcompleted? |  |
| 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 AdmissionDate : | CurrentDate : | 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