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| **Patient details** | | | | | | | | | | | |
| Patient Name: | | | | | | | | | DOB: | | NHS Number: |
| Address: | | | | | | Postcode: | | | | | |
| Email: | | | | | | | | | Telephone number: | | |
| Ethnicity: | | | | Interpreter required: No  Yes  Language: | | | | | | | |
| NOK in case of emergency (must be completed): | | | | | | | | | | | Telephone number: |
| Contact to make appointment (if not patient or NOK): | | | | | | | | | | | Telephone number: |
| Do they live alone: Yes  No | | Access Details: | | | | | Details of any risk to home visit: | | | | |
| Has the patient been identified as being vulnerable (in relation to Covid) by their GP or consultant? Yes  No | | | | | | | | | | | |
| GP: | | | | GP address: | | | | | | | |
| GP Telephone number: | | | | GP email: | | | | | | | |
| **Reason for Referral** | | | | | | **Patient consented to referral (must be given): Yes** | | | | | |
| Reason for referral including patient’s own rehab goal, particular task or activity the patient wants to work on: | | | | | | | | | | | |
| Has there been a recent admission to hospital No  Yes  If yes, please provide the following details: | | | | | | | | | | | |
| Admission date: | | | | Discharge Date: | | | | | | | |
| Hospital admitted to: | | | | Reason for admission: | | | | | | | |
| Relevant Past Medical History: | | | | | | Current Medication (GP please attached medication summary): | | | | | |
| **Falls** | | | | | |  | | | | | |
| Is the person falling/at risk of falling? Yes  No  Frequency of Falls: Daily  Weekly  Monthly  Rarely    Date of last fall:  Cause of falls/risk of falling if known:  If urgent input is needed please refer to intermediate care  **UPA 020 3049 5751** | | | | | | Have the falls been investigated?  Yes  No  If yes please provide details: | | | | | |
| **Mobility** | | | | | | | | | | | |
|  | **Level of dependence** | | | | | **Transfer/Mobility Aid** | | | | | |
| Transfers | Independent  Assistance of 1  Assistance of 2  Unable | | | | | Detail transfer aid: | | | | | |
| Indoor mobility | Independent  Assistance of 1  Assistance of 2  Unable | | | | | Rollator Frame  Crutches  Sticks  Other: | | | | | |
| Outdoor mobility | Independent  Assistance of 1  Assistance of 2  Unable | | | | | 3 / 4 wheeled walker  Crutches  Sticks  Other: | | | | | |
| **Home tasks and activities: How is the patient managing at home?** | | | | | | | | | | | |
| **Activity of daily living** | | | **Level of dependence** | | | | | | | **Comment** | |
| Domestic tasks (e.g. cooking, cleaning) | | | Independent  Assistance  Unable | | | | | | |  | |
| Personal tasks (e.g. washing, toileting) | | | Independent  Assistance  Unable | | | | | | |  | |
| Details of any equipment at home if known: | | | | | | | | | | | |
| Details of package of care/support if known: | | | | | | | | | | | |
| **Additional Information** | | | | | | | | | | | |
| Impaired Cognition | | | No  Yes | | Impaired Vision | | | No  Yes | | If yes, please provide details below: | |
| Communication Difficulties | | | No  Yes | | Impaired Hearing | | | No  Yes | |
| Safeguarding concerns | | | No  Yes | |  | | |  | |

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| **Falls Clinic (Location: The Whittington Centre: SW16 2DQ) (Please Tick for referral)** |
| **Purpose:**  A multidisciplinary clinic for patients whose cause of falls is unknown or have a history of multiple falls in the last year, requiring investigation. If you select this service please do not select any other.  **Please consider other Falls Clinics at Guys Hospital and Kings College Hospital which may be closer and more convenient for the patient.** |
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| **Falls Prevention Exercises (Please Tick for referral)** |
| **Purpose:**  Strength and balance exercises for falls prevention via community exercise classes, virtual exercise classes, Otago 1:1 or strength and balance group.  **Please complete this referral and attach the patient’s medical summary and send to gst-tr.strengthandbalancehelpline@nhs.net or call 0203 0495424** |
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| **1:1 Physiotherapy (Please Tick for referral)** |
| **Purpose:**  Provide Physiotherapy for adults who have experienced a change in health affecting function/falls/injuries/frail and living in the community and for people who have experienced falls where falls prevention exercises alone won’t meet their needs.   * **Please consider Musculoskeletal outpatients for patients with more specific and localised joint, tendon and muscular problems and conditions and where the patient has no identified community specific MSK goals.** * **Please refer to gst-tr.neurorehabservice@nhs.net for patients with a new neuro diagnosis or a neuro condition that needs specialist neuro rehab.** |
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| **Occupational Therapy (Lambeth Only) (Please Tick for referral)**  **For Southwark Occupational Therapy please contact Southwark Social Services via: OccupationalTherapyHelpDesk@Southwark.gov.uk** |
| **Purpose:**  To provide Occupational Therapy for adults who have experienced a change in health affecting function/falls/injuries/frail that has caused a recent change in their function to manage everyday tasks in their home environment. Occupational Therapy provides practical support to empower people to facilitate recovery and overcome barriers to promote independence in activities of daily living.  **Please refer to Lambeth Social Services OT for:**   * any major adaptations such as provision of a wet room/external rails/ramps/steps/stair lift equipment provision when there no rehabilitation needs refer to https://beta.lambeth.gov.uk/adult-social-care-and-health/safeguarding/professionals-and-care-providers |
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| **Walking Aid Replacement (Please Tick for referral)** |
| **Purpose:**  To replace any walking aid that the patient already has**.** Patient needs to remain safe whilst waiting as may take a minimum of two weeks  to issue. If an urgent replacement or assessment for new walking is needed and the patient’s safety is at risk without this please refer to  **UPA 020 3049 5751** |

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| **Referrer Details** | |
| Name: | Telephone number: |
| Occupation and Service/GP: | Email address: |
| Address: | Postcode: |
| Signature: | Date: |