

**LAMBETH & SOUTHWARK**

**COMMUNITY NEUROLOGICAL REHABILITATION SERVICES REFERRAL FORM**

Please email completed referral to gst-tr.NeuroRehabService@nhs.net

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| **Name of referrer:** |  |
| **Role of referrer:** |  |
| **Contacts details of referrer:****(Team, location, telephone and email)** |  |
| **Date of referral:** |  |

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| Patient Details |
| Title |  | Address (including postcode) |
| First Name |  |
| Surname |  |
| Date of Birth |  |
| Telephone (H) / (M) |  | NHS No: |  |
| Key family or friend:Contact number/details: |  | Ethnicity |  |
| GP Name |  | Language |  |
| GP Address |  | Interpreter required? |  |

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| MEDICAL INFORMATION |
| **Primary neurological diagnosis:** Date of diagnosis:**Medical issues related to the conditions:** **Medically stable for therapy** Y [ ]  N [ ]  *Details:* |
| **Main diagnosis related impairments:**1.2.3.4. |
| **Key treating team:**Consultant (name and contact details):Clinical nurse specialist:Date last clinic appointment: Last clinic appointment letter attached Y [ ]  N [ ]   Date future clinic appointments: |
| **Past Medical History:** |
| **Mood/ psychiatric diagnoses:**Has a mood screen been completed? Y [ ]  N [ ] Name of screen: Date: Score: |
| **Current medication list :** Medication list attached: Y [ ]  N [ ]

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| Drug name | Form *(liquid, tablet, crushed)* | Dose | Frequency |
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How is patient taking medications? Can patient self-administer? Y [ ]  N [ ]  Aids:  *Dossett* [ ]  *blister pack* [ ]  *carer or family*[ ]  *other* [ ] ……….. |
| **DNACPR:** Y [ ]  N [ ] **Treatment escalation plan :***Details (including if fast track funding):* |

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| **SOCIAL SITUATION** |
| Lives with  | Partner | Family | Friends | Alone  |  | Any dependants in property |  |
| Accommodation type | Include: Stairs/microenvironment/ supported living / care home  |
| Access details | Can the person open the door Y [ ]  N [ ] Keysafe no: |
| Package of care/ informal care  | If Yes to package of care:Fast track funding [ ]  social care funding [ ]  Continuing Health funding [ ]  |
| Allocated social worker | Name: Contact details: |

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| **COMMUNICATION** |
| Expressing self |  **Can patient call for help?** Y [ ]  N [ ] *Details:* |
| Understanding others |  |
| Reading and Writing |  |
| Aphasia: Y [ ]  N [ ]  Dysarthria: Y [ ]  N [ ]  Apraxia of speech: Y [ ]  N [ ]  Cognitive communication difficulties: Y [ ]  N [ ] ***Details:*** |
| COGNITION |
| *(Orientation, attention, memory, executive functioning, visuospatial / perception, insight)* |
| Details of any capacity assessments: |

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| **EATING AND DRINKING** |
| Is the patient having oral intake? If not, are they receiving alternative feeding via: PEG: [ ]  Other [ ]  : NG – removal plan [ ]  : Risk feeding: [ ]   |
| **DIET**  |
| NBM  | Regular diet | Easy to chew (IDDSI 7) | Soft & bite sized (IDDSI 6) | Minced & moist (IDDSI 5) | Pureed (IDDSI 4) | Liquidised (IDDSI 3) |
| **FLUIDS** |
| NBM | Thin fluids | Slightly thick (IDDSI 1) | Mildly thick (IDDSI 2) | Moderately thick (IDDSI 3) | Extremely thick (IDDSI 4) |
| Is the patient maintaining their weight? Y [ ]  N [ ]  |
| Are there consistent signs of aspiration: Y [ ]  N [ ] *i.e. coughing/choking/eyes watering/face reddening/ shortness of breath*Chest infections within last 6 months: Y [ ]  N [ ]  Details:Change in swallow function? Y [ ]  N [ ]  Details:Any report of reflux/ or known reflux related conditions? *i.e. GORD* Y [ ]  N [ ]  If yes, has this been investigated Y [ ]  N [ ] *Details:* |

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| **therapy AND NURSING** |
| **Please fill in the table below using the following level of function codes:** |
| **I**  | Independent | **S**  | Supervision | **V**  | Verbal Prompting |
| **A1**  | Assistance of 1 |  **A2**  | Assistance of 2 | **H**  | Hoist |
| Please indicate transfer equipment (if other than hoist) |
|  | Previously *Approx date:* | **Current abilities/ changes made in therapy** |
| **Mobility and transfers** |
| Bed mobility |  |  |
| Transfers |  |  |
| Shower/ Bath transfers |  |  |
| Getting around indoors |  |  |
| Stairs |  |  |
| Falls history | Any falls in past 12 months: Y [ ]  N [ ]  If yes, how many:Details: |
| **Personal Care** |
| Feeding / Eating |  |  |
| Dressing |  |  |
| Washing |  |  |
| Toileting/continence |  |  |
| **Skin integrity**  |  |  |
| Any pressure sores:*Details:*Risk of pressure sore:*Details:* | Y [ ]  N [ ] Y [ ]  N [ ]  | Y [ ]  N [ ] Y [ ]  N [ ]  |
| **Domestic / Community** |
| Meal preparation |  |  |
| Housework/ Laundry |  |  |
| Financial management |  |  |
| Shopping |  |  |
| Getting out and about |  |  |

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| **SAFEGUARDING***i.e. substance abuse, environmental, family dynamic* |
| Concern | Details | Management plan |
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| **REASON FOR REFERRAL** |
| **Patient priorities:**1.2.3.4. |
| **Suggested therapy disciplines**: OT [ ]  PT [ ]  SLT [ ]  *N.B external referrals to neuropysch not accepted (referrals to neuropsych from internal MDT referrals)* |
| **Environment, Access and Equipment provision** (space for treatment, cleanliness/hygiene, telecare, equipment in situ, pets) |

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| **ONGOING REFERRALS, INVESTIGATIONS, OUTPATIENT APPOINTMENTS**Please list as appropriate |
| GSTT Wheelchair Service |  |
| Social Services |  |
| Continence |  |
| Orthotics |  |
| Vocational rehabilitation |  |