

**LAMBETH & SOUTHWARK**

**COMMUNITY NEUROLOGICAL REHABILITATION SERVICES REFERRAL FORM**

Please email completed referral to [gst-tr.NeuroRehabService@nhs.net](mailto: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   |  |  |  |  | | --- | --- | --- | --- | | Drug name | Form *(liquid, tablet, crushed)* | Dose | Frequency | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   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 |  |