Holy Cross Hospital
Haslemere,
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REFERRAL FORM

Patient Name:	**Home address :**
DOB:	**Date of referral:**
Referred by: **Name:** **Job title:** **Organisation:**	**Diagnosis:**

Past medical history:
Recent history:

Current medication:
Breathing (*please tick as appropriate)* ☐ Tracheostomy Type/size: Date last changed: ☐ Cuffed ☐ Uncuffed ☐ Ventilator Please give details Other relevant details:

Nutrition (*please tick as appropriate)*

Weight Height (if known)

□ Oral diet □ Modified consistency Please give details

□ Assistance with feeding Please give details

□ Enteral feeding □ PEG □ RIG Type/size Date last changed:

Enteral feed
Type

Amount in 24 hrs

Rate per hour

Water (volume in 24 hours)

Other relevant details

Elimination *(please tick as appropriate)*

□ Independent
□ Needs assistance to toilet/commode
□ Incontinent of urine
□ Incontinent of faeces
□ Urethral catheter Type/Size: Date last changed**:**
□ Suprapubic catheter Type/Size: Date last changed**:**

Other relevant details

Tissue viability *(please tick as appropriate)*

Waterlow score
□ Skin intact
□ Pressure ulcer Grade Treatment

Other relevant details

Cognition and communication

□ Fully aware, able to understand and communicate without assistance
□ Needs communication aid (please describe)
□ Difficulty understanding and processing information
□ Memory problems
□ Low awareness state

Other relevant details

Behaviour (*please describe any problems)*

□ No problems with behaviour
□ Irritable at times
□ Impulsive
□ Verbally aggressive
□ Physically aggressive
□ Disinhibited
□ Lacks insight

Other relevant details

Mobility and posture management

□ Able to move or turn in bed independently
□ Able to move or turn in bed with assistance
□ Unable to move or turn in bed
□ Able to walk independently
□ Able to walk with assistance
□ Wheelchair bound
□ Has own wheelchair/ seating system
□ Has a wheelchair/ seating system on loan
□ Has been referred to local wheelchair/ special seating services
□ Yet to be referred to wheelchair/ special seating services
□ Patient using pressure relieving/ air mattress
□ Patient using a special sleep system (Dreama/ Symmetrikit)

Other relevant details

Transfers

□ Able to transfer independently
□ Able to transfer with assistance (banana board/ staff assistance)
□ Transferred using a hoist and sling

Other relevant details

Therapy interventions (PT/OT/SLT)

□ Patient receives therapy daily
□ Patient receives therapy once/ twice weekly
□ Patient receives therapy as required
□ Patient does not receive any therapy

Other relevant details (splinting, respiratory physio, Environmental Control System, hydrotherapy etc)

Tone Management

□ Has increased muscle tone managed with oral medications
□ Has increased muscle tone managed with Btx injections/ oral medications
□ Has increased muscle tone managed and awaiting appointment from specialists

Other relevant details (Phenol, IT Baclofen, contractures/ deformities)