

INPATIENT REFERRAL FORM

Referrer's details

Name:		Contact phone number:
Job title:	Organisation:	
Email:		

Patient's details

Patient name:	DOB:
Current address:	
Date of referral:	NHS number:
Diagnosis:	

Medical condition(s) *(please tick as appropriate)*

- Acquired Brain Injury (either Hypoxia or Traumatic Brain Injury)
- Spinal cord Injury
- Peripheral neuromuscular disease e.g. Guillain Barré syndrome, critical illness neuropathy
- Patients requiring complex respiratory care, eg tracheostomy and ventilator
- Patients requiring complex spasticity management including botulinum toxin
- Patients with neurodegenerative disorders (eg multiple sclerosis, Parkinson's Disease etc.) requiring specialist rehabilitation
- Stroke
- Motor Neurone Disease
- Post neurosurgery and major joint orthopaedic rehabilitation
- Functional neurological disorders
- Patients with prolonged disorders of consciousness (PDOC)
- Learning disability/Autism
- Dementia
- Challenging behaviour
- Transitional care for 18 years older
- Respite care
- Other:

Additional information:

Previous medical history:

Respiratory: *(please tick as appropriate)*

Tracheostomy If ticked, please state type/size:

Cuffed Uncuffed

Oxygen If ticked, please give details:

Ventilator If ticked, please give details:

Cough assist If ticked, please give details:

Humidifier

Speaking valve

Other relevant details:

Nutrition: *(please tick as appropriate)*

Weight

Height (if known)

Oral diet

Modified consistency

If ticked, please give details:

Assistance with feeding

If ticked, please give details:

Enteral feeding

If ticked, please state type/size:

Enteral feed

Type

Amount in 24 hours

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

If ticked, please state type/size:

Suprapubic catheter

If ticked, please state type/size:

Other relevant details:

Tissue viability: *(please tick as appropriate)*

Waterlow score

Skin intact

Pressure ulcer

If ticked, please state grade:

Treatment:

Tissue viability nurse involved

If ticked, please give details:

Other relevant details:

Cognition and communication: *(please tick as appropriate)*

Fully aware, able to understand and communicate without assistance

Difficulty understanding and processing information

Memory problems

Low awareness state

Needs communication aid

If ticked, please describe:

Other relevant details:

Does the patient have capacity to consent for admission?

Yes

No

Behaviour: *(please tick as appropriate)*

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

Other relevant details:

Mobility and posture management: *(please tick as appropriate)*

- 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

Other relevant details:

Transfers: *(please tick as appropriate)*

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): *(please tick as appropriate)*

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: *(please tick as appropriate)*

Has increased muscle tone managed with oral medications

Has increased muscle tone managed with Botox injections/oral medications

Has increased muscle tone managed and awaiting appointment from specialists

Other relevant details:

(Phenol, IT Baclofen, contractures/ deformities)

Next of kin details

Name:

Contact phone number:

Email:

Address:

Additional information

Please email the completed inpatient referral form to:
hchgu27.admissions@nhs.net