Sussex Community NHS
NHS Foundation Trust

Intermediate Care Unit - In-Patient Rehabilitation (IPR) Referral Form

Patient Name: ADDRESSOGRAPH **DOB:**	**NHS No:** **Hospital No:** **Referring ward**	**Date of Admission:** **ReSPECT:** **DNACPR:** **MRFD: Yes / No (circle)**
Reason for admission:		
Past Medical History:		
Current Observations – HR ☐ BP ☐ Resps' ☐ Sats ☐ Temp' ☐ Current NEWS: ☐		

First language:	Interpreter required: **Y / N**	
Ethnicity:	Religion:	
Please circle Accommodation Type: – House – Bungalow – Flat – Bed & Breakfast – Residential Home – Nursing Home - Supported Living -		
Next of Kin – Name, address and Postcode: Contact number:		
Referrer's Details – Name: Ward: Contact Number:	GP Details: Name, address and Postcode: Contact number:	
Clinic follow ups:	Flu Vac: Date if known:	Infection control status:

Reason for Referral / Goals:

Current needs regarding emotional/mental health support (Please give brief description)

Alert/orientated:	Confusion/ disorientated:	Mild memory issues:	Any episodes of wandering during the day or night:	Diagnosis of mental health issues: (Dementia/ Alzheimer's/Bi polar)	Other issues:

Communication Needs

Current MUST score: …… Weight……BMI…….. Dietician referral **YES / NO** Date:……..

Wounds **YES / NO**

If Yes, please state type of wound and dressing required:……

Are Pressure Areas Intact **YES / NO** If No, state category of damage:

1	2	3	4

Please email this completed referral form to: **sc-tr.patientflowcentre@nhs.net**

Please indicate in the email subject box which team the referral is for i.e. EAST / WEST or Central

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Please state where damage is and current treatment: Pain management:

Current equipment requirements: (special mattress/bariatric equipment/commode)

Commode	Urinal	Hospital Bed	Pressure Mattress (type):	Other:	**Standard / Bariatric**

Current needs regarding mobility/transfer

Mobility Independent without aids? **YES / NO** *if with aids, state type*:

Zimmer frame	Wheeled Zimmer	Gutter frame	Walking stick	4 wheeled walker

Transfers

Independent	Assistance of x1	Assistance of x2	Use of hoist	Stand-aid

Current care support needs

Washing/dressing:

Independent	Assistance of x1	Assistance of x2

Eating/drinking:

Independent	Assistance of x1	Full support: PEG/ NG	Other (please state):

Continence

Independent	Commode	Urinal	Catheter	Incontinent

Please state support required,
I.e. pads used/ assistance at night……

Night time support:

Independent	Urinal	Commode	Bedpan	Turning

Current needs regarding medication support

Prior to hospital admission was patient able to take own medication **YES / NO**
If no, please state who was providing support with this:…….

Is medicine supplied in **BOXES / BLISTER PACKS at home**
Was patient on insulin prior to hospital admission **YES / NO** If yes, who was providing this support:……..

Package of care (POC) provided prior to hospital admission **YES / NO**
If yes, How many calls a day?..... Agency name……

Recommendations for future Care: ……

Any other relevant information::

I agree that my information can be shared, on a need to know basis and in strict compliance with the law, with other people or organisations involved in my care:

YES / YES with limitations / NO / No with limitations

Please list any person(s) you do not want to share this information with:

RN Name:	Signature:	Date:	Time:
AHP Name: Bleep No:	Signature:	Date:	Time:

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