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| **CONFIDENTIAL –**  **East Surrey and Sussex Community Stroke and Neuro Rehab Assessment** |
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| [FCHCCIC.CSNRT@nhs.net](mailto:FCHCCIC.CSNRT@nhs.net) |  | Fax One Call 01273 254214 |
| [SC-TR.OneCall-North-ReferralsOnly@nhs.net](mailto:SC-TR.OneCall-North-ReferralsOnly@nhs.net) |
| Reablement [SAShospital@surreycc.gcx.gov.uk](mailto:SAShospital@surreycc.gcx.gov.uk) (subject ‘ESD referral’) |  |
|  |
| **CLIENT/PATIENT DETAILS** |
| Title: Mrs | Name: | Known As: |
| NHS Number: |  | Date of Birth: |  |
| Address: | Telephone Number: |
| Home |
| Mobile: |
| Next of Kin: | Telephone Number: |
| GP Name: | GP Address: |
| Consultant Name: Choose an item. | Consultant Address: |
| **SIGNIFICANT DATES** |
| Admission Date: | Expected Date of Discharge: | Date of referral: |
| **MEDICAL HISTORY** |
| Present Neurological Condition (including CT/MRI result): | Date of Onset: |
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| Medical History: |
| Known Allergies: |
| Current Medication (Please attach MAR chart): |
| **FALLS** |
| Number of falls: |  | Most Recent Fall: |  |
| Reason/Circumstances: |

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| **SOCIAL HISTORY** | | | | | | | |
| **Lives:** Choose an item. | | | | | | | |
| **Details:** | | | | | | | |
| **Does Relative/Carer work? (Please give details): No.** | | | | | | | |
| **Lives in:** | | | | **Floor:** | | | |
| **Owner:** Choose an item. | | | | | | | |
| **Internal Access:** Stairs – does patient need to use internal stairs? Choose an item. | | | | | | | |
| Bannister ascending: Right | | | Hand rails: Choose an item. | | | Stair Lift: Choose an item. | |
| **External Access:** Choose an item. | | | | Number of steps ( ) | | | |
| **LEVEL OF SUPPORT** | | | | | | | |
| **Preadmission:** Choose an item. | | | | **Current:** Choose an item. | | | |
| Details: | | | | Details: | | | |
| Package of Care: Choose an item. | | Single  Double | | Previous Package of Care (if yes restart date)? | | | |
| Private funded  Social Service funded Reablement | | | | Package of Care:Choose an item. | | | Single  Double |
| Care Agency:  Contact Number: | | | | Private funded  Social Service funded  Reablement  Requesting from ESD Service | | | |
| **Community Alarm in Situ:**  Pull Cord Alarm:No | | | | Care Agency:  Contact Number: | | | |
|  | | | | **Community Alarm Required?:** Choose an item.  If needed for discharge must be in place before patient discharge | | | |
| **Professionals involved in care:**  DN  ( ) per week Community Matron  Specialist Nurse  Social Service  Details: | | | | **Professionals involved in care:**  DN  ( ) per week Community Matron  Specialist Nurse  Social Service  Details: | | | |
| **MOBILITY** | | | | | | | |
| **Preadmission:**  **Weight-Bearing Status:** FWB  NWB for ( ) weeks | | | | **Current:**  **Weight-Bearing Status:** FWB  NWB for ( ) weeks | | | |
| **Assistance:** Independent | | | | **Assistance:** Independent | | | |
| **Aid Used: none** | | | | **Aid Used: none** | | | |
| **Distances:** | Indoors:  Outdoors: | | | **Distances:** | Indoors:  Outdoors | | |
| **Stairs: Independent** Rails: Left  Right | | | | **Stairs: Supervision** Rails: Left  Right | | | |
| **OTHER – e.g. balance, tone, pain, seating needs (including pressure cushions and sitting tolerance), standing (tolerance, specific handling, prompts required), gait analysis, splints (where / any regime for wearing)** | | | | | | | |
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| **TRANSFERS** | |
| **Preadmission:**  **Chairs Transfers:**  Equipment: | **Current:**  **Chair Transfers:**  Equipment/Set Up/Prompts: |
| **Toilet Transfers:**  Equipment: | **Toilet Transfers:**  Equipment/Set Up/Prompts: |
| **Bed Transfers:**  Equipment: | **Bed Transfers:**  Equipment/Set Up/Prompts: |
| **ACTIVITIES OF DAILY LIVING** | |
| **Preadmission:**  **Washing/Bathing:**  Equipment: | **Current:**  **Washing/Bathing:**  Equipment/Set Up/Prompts: |
| **Dressing:**  Equipment: | **Dressing:**  Equipment: |
| **Toileting:**  Equipment: | **Toileting:**  Equipment: |
| **Meal Prep:**  Equipment: | **Meal Prep:**  Equipment: |
| **Other Information:**  Working: Yes  No  Occupation:  Driving: Yes  No  Has patient been advised regarding driving restrictions? Yes  No  N/A | |
| **COMMUNICATION: Provide details and severity of impairments and results of any assessments carried out** | |
| **Preadmission:**  Language spoken: English Interpreter required?  Any other Information or communication needs? (e.g. hearing aid, BSL etc) | **Current:** |
| **VISION: Provide details e.g. glasses, cataracts, hemianopia, visual field, ability to read** | |
| **Preadmission:** | **Current:** |
| **HEARING**: use of aids etc. | |
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| **UPPER LIMB USE IN FUNCTION:** | |
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| **COGNITION, BEHAVIOUR AND MOOD/ FATIGUE** | | | | |
| General cognitive / behavioural presentation / findings of cognitive screen:  General mood presentation / Findings of mood screen:  Behaviour issues / Aggression / Low motivation:  Comments: | | | Name of standardised cog assessment (e.g. MOCA or other cognitive assessment):  Date completed:  Score:  Name of standardised mood assessment:  Date completed: Score: | |
| Fatigue / Sleep hygiene / Sleep disturbance: (Comments) No concerns | | | | |
| Do difficulties impact on the ability to engage in therapy? Yes  No  Please explain if yes: | | | | |
| **Barthel:**  **Modified Rankin Score:** | | Date Completed:  Date Completed: | | Score:  Score |
| **SWALLOWING AND NUTRITION*:*** | | | | |
| **Dysphagia:** Yes  No | Clinical indicators observed: (e.g. coughing on thin fluids) | | | |
| Assessment Summary: | | | | |
| **Status:** | | | | |
| **Diet:** | | | | |
| **Fluids:** | | | | |
| Discharged with thickener  …… scoops per mls of | | | | |
| Saliva Management: Adequate  Inadequate | | | | |
| **Meds:** Oral  Non-oral  Strategies: | | | | |
| Dietitian Involved? Yes  No  (please give details - West Sussex / SCFT patients - First Dietitians are only commissioned to see enterally fed patients in their own home/care home; other patients are seen as out patients appts) | | | | |
| Nutritional prescription provided (sip feeds and/enteral feed)? Y  N  (please give details) | | | | |
| **DISCHARGE PLANS (if appropriate)** | | | | |
| Discharge destination: Home  Package of care organised: Y  N/A  Details (start date): Reablement to start | | | | |
| Access Arrangements: Able to answer door: Y  N  Family available to answer door: Y  N  Able to call for help: Y  N  Keysafe *(please provide team with number)*  Other: | | | | |
| Adequate cognitive and communication ability to be considered safe (able to call for help / remember safety advice)  Has mental capacity assessment been completed and if so for what: : Y  N  Outcome of assessment | | | | |

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| Risk Factors for lone working (e.g. pets, access, safety, smoking, alcohol, N/A – please circle): None  Any safeguarding concerns: None | | | |
| **REHAB GOALS (if none please N/A)** | | | |
| Occupational Therapy | | | |
| - | | | |
| Physiotherapy | | | |
| - | | | |
| Speech and Language Therapy | | | |
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| Nursing | | | |
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| Other (e.g. psychology, dietetics, social services, other services) | | | |
| **NURSING INFORMATION** | | | |
| **Height (m):** | **Weight (kg):** | | **MUST score:**  **Date:** |
| **Previous weight (kg) Date:** | | **If unknown estimate if:** Choose an item. | |
| **Infection Risk** | | | |
| **Allergies:** Yes  No  **List Allergies:**  **Medication Management:**  **Medications management by: Patient** | | | |
| Medical discharge summary sent:(tick box)  MAR chart sent: (tick box)  24 Hour observation attached (tick box)  Baseline blood results attached (tick box)  Do they need help at night? Y  N  details: | | | |

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| **CONTINENCE** | | | | | |
| **Preadmission:**  **Bladder:**  **Equipment:**  **Bowel:**  **Equipment:** | | | **Current** (if incontinent , how managed e.g. pads / intermittent catheterisation):  **Bladder:**  **Equipment:**  **Bowel:**  **Equipment:** pads  **When bowels last opened?**  **Grading on Bristol Stool Chart**  **Bladder management passport?** Y  N | | |
| Continence strategy in place Y  N/A  Details (e.g. frequency, how often pads to be changed, overnight needs?) | | | | | |
| **SKIN -** Provide details of pressure sores/ability to relieve/management plan | | | | | |
| **Braden Score:** | | | | | |
| **REFERRER DETAIL** | | | | | |
| Name | Signature | Profession | | Contact Number/ Email | Date |
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| **UPDATES (signed and dated as appropriate)** | | | | | |
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