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| **CONFIDENTIAL –****East Surrey and Sussex Community Stroke and Neuro Rehab Assessment** |
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| FCHCCIC.CSNRT@nhs.net |  | Fax One Call 01273 254214  |
| SC-TR.OneCall-North-ReferralsOnly@nhs.net  |
| Reablement 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:** FWBNWB 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 [x]  Occupation:Driving: Yes [x]  No [ ]  Has patient been advised regarding driving restrictions? Yes [x]  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 [x] Please explain if yes: |
| **Barthel:** **Modified Rankin Score:**  | Date Completed: Date Completed:  | Score:Score |
| **SWALLOWING AND NUTRITION*:*** |
| **Dysphagia:** Yes [ ]  No [x]   | 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 [x]  Non-oral [ ]  Strategies:  |
| Dietitian Involved? Yes [ ]  No [x]  (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 [x]  N/A [ ]  Details (start date): Reablement to start |
| Access Arrangements: Able to answer door: Y [x]  N [ ]  Family available to answer door: Y [ ]  N [ ]  Able to call for help: Y [x]  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) [x] Has mental capacity assessment been completed and if so for what: : Y [ ]  N [x] 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 |
|  |
| Nursing |
|  |
| 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 [x]  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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