**ESD CENTRAL AREA REFERRAL FORM**

OneCall, 4th Floor Crawley Hospital, West Green Drive, Crawley,RH11 7DH

Tel: 01293 228311 email: sc-tr.onecall-north-referralsonly@nhs.net Fax: 01273 254214

**Important:** *Please ensure the patient meets the referral criteria before completing this form.* **Note:** *Referrals without all the information will be returned to the referrer and not considered for assessment by the service.*

**DATE COMPLETED: DISCHARGE DATE:**

**Patient details**

|  |  |
| --- | --- |
| Title:  | Date of Birth:  |
| Name:  | NHS Number:  |
| Address:  | Ethnicity:  |
| Next of Kin: Telephone Number:  |
| GP: Telephone number:  |
| Telephone Number:  | Referrer Name: Ward/Hospital: Solomon Ward – Stroke Unit (RSCH)Telephone Number: 01273 696955 x4590 |
| Hospital Consultant:  |

**Medical History**

|  |
| --- |
| Current Diagnosis/Presentation (*Date of onset, Scan/investigation results/vision/tone/strength/sensation)* |
| Past Medical History *(Include other medical conditions and Mental Health History)* |
| Medication on discharge *(Or please provide medical discharge summary)*Please see discharge summary. |
| BP and Pulse readings: |
| **DNAR Status** (*Please attach copy of form)* |
| Infection Control Status |
| NPDS- ***state score*** | Allergies: See medical discharge summary.  |
| Waterlow:  | MUST:  |

**Social History**

|  |
| --- |
| *Environment, Key safe, Carelink* |

**Current Functional Status**

|  |
| --- |
| *Personal Care, Mobility, Toileting day/night, Medication management*  |
| Communication |
| Continence |
| Swallow |
| Current Suicidal Ideations/Mood  |
| Cognition |

**Rehab Goals**

|  |
| --- |
| ***SMART*** *Short and Long Term Goals, disciplines required* |

**CHECKLIST Yes No**

|  |  |  |
| --- | --- | --- |
| Does the patient require input from 2 or more disciplines? |  |  |
| Is the patient having a Package Of Care on discharge?- ***if ‘Yes’, please state details below*** |  |  |
| Has the referral been explained and the patient consented? |  |  |
| Is the required equipment and Pressure Care in place for discharge? |  |  |

**Additional Information –including any known risks to patients and/or staff (e.g. risk of falls, infection, violence etc.)**

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|  |

Referrer Signature:

Name and Designation: