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

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| --- | --- | --- |
| **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’ SatsTemp’ 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 Practice name, telephone and Postcode: |
| **Discharge Pathway Indicated 1 2 3**  | Current Infection Prevention Status (tick)**Covid-19**Test not required

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Result Negative no isolation Result Positive needs isolation Awaiting test result **Flu Vac** - date if known: |
| Clinic follow ups**:**  |
|  |

**Reason for Referral / Goals:**

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|  |

**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: |

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| **Can they be cared for in a side room:****Can they use a call bell?****Can they communicate appropriately?** |
| AMT:Current MUST score: ………… Weight…………………BMI…………….. Dietician referral **YES / NO** Date:…………..  |

Wounds **YES / NO**

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

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | 2 | 3 | 4 |

Are Pressure AreasIntact **YES / NO** Grade (circle)

|  |
| --- |
| 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**

**Current Medication:**

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: ………………………………………………………………………………………………

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| --- |
| 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: Signature: Date: Time:Bleep No: |

Please email 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 Teams**