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

**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: |

|  |
| --- |
| **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: ………………………………………………………………………………………………

|  |
| --- |
| 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**](mailto: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**