Sussex Rehabilitation Centre Inpatient Rehabilitation 

Referral & Assessment Form

**Please complete all sections in order to avoid delays processing referral**

Email completed referrals to**bsuh.srcprhreferrals@nhs.net**

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| --- |
| 1. Patient Information |
| First name |       | Surname |       |
| Date of birth |       | Age |       |
| NHS number |       | BSUH hospital number |       |
| Patient’s home address |       |
| Patient’s post code |       | Patient’s telephone number |       |
| Patient’s email address |       |
| Gender |       | Marital status |       |
| Occupation |       |
| Name of CCG responsible for patient’s care |       |
| GP name |       | GP Practise name |       |
| Practise post code |       | Practise telephone number |       |
| Practise nhs.net email address |       |
| 2. Next of kin details |
| Name |       | Relationship to patient |       |
| Address |       |
| Post code |       | Telephone number |       |
| Email address |       |
| 3. Consultant/referrer information |
| Referring consultant/doctor name |       | Date of referral to SRC |       |
| Address |       |
| Post code |       | Telephone number |       |
| Referral to | Neurological rehabilitation | Dr C MehtaDr A Skinner |[ ]  Stroke | Dr Y Ng |[ ]
|  |  |  |  |  | Dr K Ali |[ ]
| Date of admission to SRC |       | Date accepted & ready to transfer |       |
| 4. Diagnosis |
| Primary diagnosis |       | Date of onset |       |
| Date of surgery (if applicable) |       | Surgical procedure |       |
| Secondary diagnosis |       |
| 5. Summary of medical/surgical history |
|       |
| Drug/alcohol use |       |
| History of deliberate self harm |       |
| Previous physical & cognitive function |       |
| 6.Investigations |
|  | Yes | No | If yes, date | Comments/further details |
| CT scan |[ ] [ ]        |       |
| MRI |[ ] [ ]        |       |
| Other |[ ] [ ]        |       |
| If the patient has had a stroke, please complete the following: |
|  | Yes | No | If yes, date | Comments/further details |
| Echocardiogram |[ ] [ ]        |       |
| Carotid doppler/duplex |[ ] [ ]        |       |
| ESR |[ ] [ ]        |       |
| Auto-antibody screen |[ ] [ ]        |       |
| Other |[ ] [ ]        |       |
| 7. Current medication |
| 1. |       | 4. |       |
| 2. |       | 5. |       |
| 3. |       | 6. |       |
| 7. |       | 8. |       |
| 9. |       | 10. |       |
| 11. |       | 12. |       |
| 8. Any additional medical/surgical information |
|       |

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| 9. Summary of disabilities |
|  | Yes | No | Comments/further details |
| Altered state of awareness |[ ] [ ]        |
| Cognitive/communicative problems |[ ] [ ]        |
| Behavioural problems |[ ] [ ]        |
| Physical deficits |[ ] [ ]        |
| Higher respiratory needs |[ ] [ ]        |
| 10. Current rehabilitation input |
|  | Yes | No | Comments/further details |
| Physiotherapy |[ ] [ ]        |
| Occupational therapy |[ ] [ ]        |
| Speech and language therapy |[ ] [ ]        |
| Psychology |[ ] [ ]        |
| Dietetics |[ ] [ ]        |
| Social work |[ ] [ ]        |
| Please attached additional reports from the therapists currently involved in the care of the patient, or arrange for then to be sent. |
| 11. Mobility and transfers |
| **Transfers (tick 1)** | **Mobility** |  | **Risk of falls** |
| Independent |[ ]  Walking | Wheelchair | Yes |[ ]
| Assistance from 1 |[ ]  Independent |[ ]  N/A |[ ]  No |[ ]
| Assistance from 2 |[ ]  Supervision/help from 1 |[ ]  Pushed in a wheelchair |[ ]   |
| Hoist |[ ]  Supervision/help from 2 |[ ]  Independent |[ ]   |
| Bedbound |[ ]   | Has own chair (Yes/No) |       |       |
|  |  | If yes, is it suitable? (Yes/No) |       |       |

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| 12. Cognition and communication |
| Level of communication: | Consistent yes/no responses |[ ]  Single word level |[ ]   |
|  | Sentences |[ ]  Full phrases |[ ]   |
|  |
|  | Yes | No | Comments/further details |
| Cognitive problems |[ ] [ ]        |
| Perceptual problems |[ ] [ ]        |
| Ability to learn |[ ] [ ]        |
| Other |[ ] [ ]        |
|  |
| Dysphasia |[ ] [ ]        |
| Expressive dysphasia |[ ] [ ]        |
| Receptive dysphasia |[ ] [ ]        |
| Dysarthria |[ ] [ ]        |
| Other |[ ] [ ]        |
|  |
| Capacity to consent? (Yes/No) |[ ] [ ]   |
|  | Yes | No |
| If no, has a Deprivation of Liberty Safeguards been undertaken, including involvement of Independent Mental Capacity Advocate? |[ ] [ ]
| 13. Vision and hearing |
|  | Yes | No | Comments/further details |
| Visual problems |[ ] [ ]        |
| Hearing problems |[ ] [ ]        |

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| 14. Behavioural problems |
|  | Yes | No | Comments/further details |
| Agitation |[ ] [ ]        |
| Wandering/absconding |[ ] [ ]        |
| Self harm |[ ] [ ]        |
| Verbal aggression |[ ] [ ]        |
| Physical aggression |[ ] [ ]        |
| One to one supervision |[ ] [ ]        |
|  |
|  | Yes | No |  |
| Is the patient under a mental health act detention order? |[ ] [ ]   |
| Comments/further details |       |
| 15. Nursing information |
|  | Yes | No | Comments/further details |
| Dysphagia |[ ] [ ]        |
| Oral feeding |[ ] [ ]        |
| Nasogastric feeding |[ ] [ ]        |
| PEG feeding |[ ] [ ]        |
|  |
| Pressure sores |[ ] [ ]        |
| Special mattress |[ ] [ ]        |
|  |
| Urinary incontinence |[ ] [ ]  If yes | Occasional |[ ]  Regular |[ ]
| Urinary catheter |[ ] [ ]   |
| Faecal incontinence |[ ] [ ]  If yes | Occasional |[ ]  Regular |[ ]
|  |
| MRSA |[ ] [ ]  If yes | Colonisation |[ ]  Infection |[ ]
| C difficile |[ ] [ ]   |
| Tracheostomy |[ ] [ ]  If yes | Cuffed |[ ]  Uncuffed |[ ]
|  | Weaning programme |[ ]  Stabilised |[ ]

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| 16. Type of residence and accessibility |
|  | Comments/further details |
| Lives alone |[ ]        |
| Lives with: |  |
| Parents |[ ]        |
| Husband/wife/partner |[ ]        |
| Other |[ ]  Please specify |       |
|  |
|  | Comments/further details |
| Owner/occupied |[ ]        |
| Council/housing assoc |[ ]        |
| No fixed abode |[ ]        |
| Other |[ ]  Please specify |       |
| 17. Any additional information on patient’s current level of disabilities |
|       |