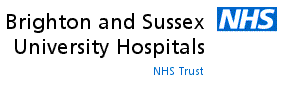
Sussex Rehabilitation Centre Inpatient Rehabilitation [](http://nww.bsuh.nhs.uk/)

Referral & Assessment Form

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

Email completed referrals to[**bsuh.srcprhreferrals@nhs.net**](mailto:bsuh.srcprhreferrals@nhs.net)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 Mehta  Dr 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 | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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) |  |  | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | |  |  |  | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 | | | |
|  | | | |