 

Greater Manchester Community Neuro-Rehabilitation Referral Form

**Greater Manchester Neuro-Rehabilitation Network**

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| **Patient Details** | | **GP Details** | |
| Name : |  | Name: |  |
| DOB: |  | Address: |  |
| NHS No: |  |
| Discharge Address : |  | Tel No: |  |
| **Next of Kin Details** | |
| Name: |  |
| Post code: |  | Relation: |  |
| Contact Tel No: |  | Contact details: |  |

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| **Referring Ward:** | |  | **Inpatient Consultant:** | |  |
| **Date of Admission:** | |  | **Follow up Consultant**  **Details:** | |  |
| **Date of Discharge:** | |  |
|  | | | | | |
| **Social Work Details** | | | | | |
| Name: |  | | Contact Number: |  | |
|  | | | | | |
| **Neurological Diagnosis:** | | | **Other Diagnoses:** | | |
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| **Date of onset:** | |  | **Date of onset:** | |  |
| **Allergies:** | |  | | | |
| **DNAR:** | | Details: | | | |

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| **Summary of Admission:** | | | |
| (Clinical presentation, Relevant Investigations/scan Results, PMH. Insert medical discharge summary if available) | | | |
| **Social History:** | Accommodation:  Employment Status/Occupation: Current Support:  Package of Care:  Access to Property e.g. Key Safe: Alcohol:  Smoking:  Other substance abuse: | | |
| **Risk to Visiting Professionals:** | Yes No  Details: | | |
| **Risk to Patient:** | (e.g. suicidal ideation/self-harm/safeguarding/substance abuse) | | |
| **First Language:** |  | **Interpreter Required?** |  |
| **RCS on**  **Discharge:** |  | | |
| **Covid-19 Status:** | Date of last swab: Covid-19 +ve Covid-19 –ve Not Known  Exposed to Covid-19 Date of exposure: Current restrictions e.g. isolating etc.: If previously diagnosed with Covid, date of diagnosis: | | |

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| **Problems on Admission:** |
| (summary of personal care needs/cognition/transfers and mobility/continence/behaviour, where applicable) |

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| **Intervention:** |
| (Goals of rehab, have they been achieved, rehab progress to date, rehab potential, outcome measures used and scores, intensity provided) |

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| **Current Status on Discharge**  (please send any relevant outcome measures) | | | | |
| **Transfers:** | Independent  Details: | Needs help | Hoisted |  |
| **Mobility and Balance:** | Independent  Details: | Needs help | Wheelchair | Bed Bound |
| **Falls:** | Yes No  Details: | | | |
| **Personal Care:** | Independent  Details: | Needs help |  |  |
| **Continence:** | Continent  Details: | Incontinent | Catheter |  |
| **Communication:** | Independent Needs help No effective communication  Details: | | | |
| **Swallowing:** | Normal  Details: | Impaired |  |  |
| **Nutrition:** | Independent  Details: | Needs help | Modified diet | Enteral feeding |
| **Respiratory Status:** | No issues Impairment Details:  Date referred to NW Ventilation Unit if applicable: | | | |
| **Cognition:** | No issues  Details: | Impaired |  |  |
| **Behaviour:** | Compliant Passive Aggressive Requires 1:1  Details: | | | |
| **Mood:** | No issues  Details: | Impaired |  |  |
| **Skin Integrity:** |  | | | |
| **Equipment Provided:** |  | | | |
| **Positioning, Seating and**  **Splinting:** |  | | | |
| **Vocational Rehab Needs:** |  | | | |
| **Driving Advice/Needs:** |  | | | |

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| **Referrer Name:** |  | | |
| **Date:** |  | **Designation:** |  |
| **Referrer**  **Signature:** |  | **Referrer Contact**  **Number:** |  |

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| **Disciplines Expected on Discharge and Identified Rehab Goals:** (please ensure receiving service  has access to below disciplines prior to referral) | | |
| Physiotherapy:  (name of professional) |  | Goals: |
| Occupational Therapy: |  | Goals: |
| Speech Therapy: |  | Goals: |
| Psychology : |  | Goals: |
| Medical: |  | Goals: |
| Specialist Nurse: |  | Goals: |
| Dietician: |  | Goals: |
| Other: |  | Goals: |

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| **Additional information:** |
| (copies of exercises or care plans/rehab prescription/maintenance programmes/outcome measures) |

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| **Referrer Name:** |  | | |
| **Date:** |  | **Designation:** |  |
| **Referrer**  **Signature:** |  | **Referrer Contact**  **Number:** |  |