**HOMEPATHWAY REFERRAL FORM**

**Referral checklist**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Pre -Referral Questions  | Yes  | No  |  |
|  | Does the patient Live in central Manchester address and registered with a Central Manchester GP?  |  |  | If No, Refer to appropriate Team or Local Community Service or Social services  |
|  | Is this patient aged over 18? |  |  | If no, please refer to Paediatric Team as appropriate? |
|  |  **ESSENTIAL CRITERIA FOR REFERRAL** (Should state YES for all the below to be accepted)1. Must have Rehab Potential
2. Must have one or more Short Term Goals to achieve in terms of their functional ability.
3. Must have provided consent and willingness to participate in Rehab
4. Be medically optimised.
5. Not actively Involved In any other Local Community services providing similar Rehabilitation services.
6. Require input from two Professional disciplines within ICT

(OT, PT OR NURSING) |  |  |  |
|  | Is this referral for a specific Neurological, Stroke (Acute/Chronic)? |  |  | If yes, please do refer to Community Neuro & Stroke team O161 2099965  |
|  | Are the patient deterioration in function impacted to active substance Misuse? |  |  | If Yes, please refer to Alcohol Helpline & Drugs Helpline  |
|  | Does patient need a rapid assessment to prevent potential Hospital Admission/  |  |  | If yes please refer to Crisis Response - 0161 5296220 / 07866117643 |
| **All aspects of the referral need to be completed, if not then it will be rejected** |
| **Patient Name:**  | **GENDER**  |
| **ADDRESS:** P**ostcode:**  | **DOB** |
| **TEL**.: | **NHS Number:**  | **ETHINICITY**  |
| **NOK:**   **Tel.:**  | **Relation:**  | **Tel.:**  |
| **GP Name:**  | **GP Practice:**  | **Tel:**  |
| **Reason For Referral:** **Recent deterioration:**   |
| **Medical History/relevant information:** **Recent Medical review Date:** **Details:**  |
| **Current mobility:****Mobility**: **Transfers**: **Aids/Equipment used:**  | **Baseline****Mobility:** **Transfers:****Aids/Equipment**  |
| **Communication issues:(Y/N) Vision : Hearing : First Language:**Interpreter needed:  |
| **Mental Health/Cognitive issues:**  |
| **Home situation:** **Access details:**  |
| **Safety concerns:**  | **Animals in property:**  |
| **POC**   **Details:** **Are the any other services involved:**  |
| **Service required: OT PT NURSE**  |
| **Name of referrer: Contact no: Profession**  |

All aspects of the referral need to be completed, if not then it will be rejected

Please Send the referral Via email:

Email to: mft.central.intermediate.care@nhs.net

For Queries Please Ring: 07791574469 (Duty Phone)

FOR OFFICE USE

|  |
| --- |
| PLEASE TICK ONCE COMPLETED Ax Board – EMIS SCANNED-Triage Completed - |