 

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:** |  |
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| **Social Work Details** |
| Name: |  | Contact Number: |  |
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| **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 NoDetails: |
| **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 KnownExposed 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:** | IndependentDetails: | Needs help | Hoisted |  |
| **Mobility and Balance:** | IndependentDetails: | Needs help | Wheelchair | Bed Bound |
| **Falls:** | Yes NoDetails: |
| **Personal Care:** | IndependentDetails: | Needs help |  |  |
| **Continence:** | ContinentDetails: | Incontinent | Catheter |  |
| **Communication:** | Independent Needs help No effective communicationDetails: |
| **Swallowing:** | NormalDetails: | Impaired |  |  |
| **Nutrition:** | IndependentDetails: | Needs help | Modified diet | Enteral feeding |
| **Respiratory Status:** | No issues Impairment Details: Date referred to NW Ventilation Unit if applicable:  |
| **Cognition:** | No issuesDetails: | Impaired |  |  |
| **Behaviour:** | Compliant Passive Aggressive Requires 1:1Details: |
| **Mood:** | No issuesDetails: | 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 servicehas 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:** |  |