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| **CENTRAL MANCHESTER INTEGRATED COMMUNITY REHABILITATION SERVICES**  **REFERRAL FORM** | | | | |
| **Name:** | **DOB:** | | **NHS No:** | |
| **Address:**  **Tel No:** | | **GP:**  **Address:**  **Tel No:** | | |
| **Carer details:**  **Relationship:**  **Tel No:** | | **Emergency contact (if different from carer):**  **Relationship:**  **Tel No:** | | |
| **Any issues that might affect the safety of a lone therapist?**  **Access issues** *(Keysafe code etc):* | | | | |
| **Gender:** | | **Interpreter Needed: Y / N**  **Language:** | | |
| **Communication Issues:** | |
| **Medical History:** | | **Referral made to Social Services? Y / N**  **Reason for Social Services referral:**  **Care package details:** | | |
| **Patient aware /consented to referral?** | **Y / N** | **NOK / Carer aware of referral?** | | **Y / N** |

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| **Name:** | **DOB:** | | **NHS No:** | |
| |  |  | | --- | --- | | **Additional information required for triage:** | **Must provide:** | | * Post-operative patients | * Post-op notes & relevant protocols | | * Recent hospital admission | * Discharge summary | | * All patients | * Any relevant diagnostic imaging results | | * Falls | * Complete FRAT |  |  | | --- | | **FRAT:** | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  | **Y** | **N** | **How Many?** | | **1** | History of falls in the previous year? |  |  |  | | **2** | Four or more medications per day? |  |  |  | | **3** | Diagnosis of stroke or Parkinson’s disease? |  |  |  | | **4** | Reports any problems with their balance? |  |  |  | | **5** | Does the patient **have to use** their arms to stand from a chair of knee height? |  |  |  | |   **Referrals for equipment ONLY: send to Manchester City Council Contact Centre Tel: 0161 255 8250**  **REASON FOR REFERRAL:**  *Please give as much information as possible, including rehabilitation goals.* | | | | |
| **Referred by:**  **Designation:**  **Tel No:** | | **Address:**  **Signed:**  **Referral date:** | |

**Please send to:** [**mft.centralmcrcommunityrehab@nhs.net**](mailto:mft.centralmcrcommunityrehab@nhs.net)