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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:** |
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| **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
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| **FRAT:** |
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|  |  | **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? |  |  |  |

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**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**