Bromley Healthcare
better together

Bromley Community Neuro-Rehab and Support Service

Neuro-Rehabilitation (non-stroke) Referral Form

Email: bromh.communityneuro@nhs.net or call 0300 330 5777

1. Patient details			
Title:	**First Name:**	**Surname:**	
NHS Number:	**Date of birth:**	**Gender:**	**Age:**
Address:			
Telephone: (Home)		(Mobile)	
Ethnicity:			
Patient's present whereabouts **In-patient on**	**Ward at**		**Hospital**
Hospital Address:			
Telephone:	**Facsimile:**		
At home at the above address ☐	**Other:**		

2. Consultant / referrer details	
First Name:	**Surname:**
Organisation name:	
Address:	
Telephone:	**Facsimile:**

3. General Practitioner details	
First Name:	**Surname:**
Surgery name:	
Address:	
Telephone:	**Facsimile:**

4. Carer details		
Title:	**First Name:**	**Surname:**
Address (if different to patient's):		
Telephone: (Home)		(Mobile)
Relationship to patient:		

5. Next of kin details		
Title:	**First Name:**	**Surname:**
Address (if different to patient's):		
Telephone: (Home)		(Mobile)
Relationship to patient:		

6. Diagnosis

Primary diagnosis:	**Date of onset:**
Date of surgery (if applicable):	**Surgical Procedure:**
Secondary diagnosis:	
Relationship to patient:	

7. Reason for referral

Intensive multidisciplinary rehabilitation	
Disability management	☐
Advice for appropriate placement	☐
Other	☐
If other, please specify:	☐

8. Summary of medical/surgical history

Drug / alcohol use:
History of deliberate self-harm:
Previous physical and cognitive function:

9. Investigations

	Yes	No	If yes, date:	Comments / further details:
CT scan	☐	☐		
MRI	☐	☐		
Other	☐	☐		

10. Current medication

1.	**4.**
2.	**5.**
3.	**6.**

11. Any additional medical / surgical information (including past medical history)

12. Summary of disabilities

	Yes	No	Comments / further details:
Altered state of awareness	☐	☐	
Cognitive/communicative problems	☐	☐	
Behavioural problems	☐	☐	
Physical deficits	☐	☐	
Higher respiratory needs	☐	☐	

13. Mobility and transfers

Transfers (tick one)		Mobility – Walking		Mobility - Wheelchair	
Independent	☐	Independent	☐	N/A	
Assistance from one	☐	Supervision/help from one	☐	Pushed in a wheelchair	☐
Assistance from two	☐	Supervision/help from two	☐	Independent	☐
Hoist	☐			Has own chair	Yes/No
Bedbound	☐			If yes, is it suitable?	Yes/No

Risk of falls: Yes ☐ No ☐

14. Vision and hearing

	Yes	No	Comments / further details:
Visual problems:	☐	☐	
Hearing problems:	☐	☐	

15. Cognition and communication

Level of communication (please tick as appropriate)

Consistent yes/no responses ☐ Single word level ☐ Sentences ☐ Full phrases ☐

	Yes	No	Comments / further details:
Cognitive problems	☐	☐	
Perceptual problems	☐	☐	
Ability to learn	☐	☐	
Other	☐	☐	
Expressive dysphasia	☐	☐	
Receptive dysphasia	☐	☐	
Dysarthria	☐	☐	
Other	☐	☐	

16. Capacity

Has a formal capacity assessment taken place?	Yes ☐	No ☐	Capacity to consent	Yes ☐	No ☐
If no, has a Deprivation of Liberty Safeguards order been implemented?				Yes ☐	No ☐
Is a Safeguarding referral required?				Yes ☐	No ☐

17. Behavioural problems

	Yes	No	Comments / further details:
Agitation	☐	☐	
Wandering / absconding	☐	☐	
Self-harm	☐	☐	
Verbal aggression	☐	☐	
Physical aggression	☐	☐	
One to one supervision	☐	☐	
Is the patient under a Mental Health Act detention order?	☐	☐	

18. Additional information on patient's current level of disabilities

Please include specialist equipment and onward referrals in place:

19. Measurements

Height and weight:	Body Mass Index:	MUST Score:

20. Nursing information

	Yes	No	Comments / further details:	
Dysphagia	☐	☐		
Oral feeding	☐	☐		
Nasogastric feeding	☐	☐	Date of insertion:	Tube size:
PEG	☐	☐	Date of insertion:	Tube size:
Other feeding tubes	☐	☐		
Feeding regime				
			(or attach a copy of the regime)	
Who does the feeding for the patient?				
Pressure sores	☐	☐		
Urinary incontinence	☐	☐	If yes, occasional ☐	regular ☐
Urinary catheter	☐	☐		
Faecal incontinence	☐	☐	If yes, occasional ☐	regular ☐
MRSA	☐	☐	If yes, colonisation ☐	infection ☐
C Difficile	☐	☐		
Tracheostomy	☐	☐		
Other	☐	☐		

Does the patient currently have diarrhoea and/or vomiting?

21. Social situation

Occupation:	Marital status:

Lives alone ☐

Lives with:

Does the patient have any carer roles?

Cares for a friend ☐

Cares for a neighbour ☐

Cares for a relative ☐

22. Carer's Assessment

Does the patient have an informal carer?

Has a carer (see section 4) ☐

Care from relatives ☐

Care from friends ☐

No carer involved ☐

Name of informal carer (if different from section 4):

Address (if different from patient's/section 4):

Telephone: (Home) (Mobile)

Relationship to patient:	Age (if between 4-18 years old):

Requires referral to Carer's Support Agency Yes ☐ No ☐

Referral to Carers Bromley declined Yes ☐ No ☐

Does carer state they are able to cope with their care responsibilities?

Carer able to cope ☐ Carer unable to cope ☐

Professional care in place:

Under care of social services ☐

Meals on wheels ☐

Home help ☐

No Longer receives domiciliary services ☐

Social services care manager:

Contact details:

Previous package of care including agency and number of times a day:

Community providers involved ☐

District nurse attends ☐

Under care of community matron ☐

Under care of community palliative care team ☐

Dementia link worker – mental health CPN ☐

Under care of community psychiatric nurse ☐

Other (please specify): ☐

23. Home environment

Lives in terraced house	☐	Lives in ground floor flat	☐
Lives in semi-detached house	☐	Lives in lower floor flat	☐
Lives in detached house	☐	Lives in upper floor flat	☐
Lives in bungalow	☐	Lives in residential home	☐
Lives in maisonette	☐	Accommodation status (ECH)	☐

		Comments / further details:
Owner occupied	☐	
Council / housing association	☐	
No fixed abode	☐	

(If no fixed abode, is the patient registered homeless? Include contact details of team)

Other (please specify) ☐

Is it anticipated that the patient can return to their previous abode? Yes ☐ No ☐

If not what actions are in place to find new accommodation?

Is there a keysafe/keyholder (provide details)?

Stairs in house: has a stairs assessment been completed? Yes ☐ No ☐

Independent on stairs | Needs help on stairs | Unable to climb stairs

Toilet location: Upstairs ☐ Downstairs ☐ On one level ☐ Patient uses commode ☐

Where does the patient normally sleep?

Bed in upstairs room ☐ Bed in downstairs room ☐ Sleeps in chair ☐

Environmental hazards; home hazards identified:

Steep / unsafe stairs	☐	Cluttered living space	☐
Unsafe mats / throw rugs	☐	Keeps pets	☐
Unsafe appliances / equipment	☐	Other:	

24. Current rehabilitation input

			Comments:
Physiotherapy	Yes ☐	No ☐	
Occupational Therapy	Yes ☐	No ☐	
Speech and Language Therapy	Yes ☐	No ☐	
Psychology	Yes ☐	No ☐	
Dietetics	Yes ☐	No ☐	
Care Manager	Yes ☐	No ☐	
Nursing care	Yes ☐	No ☐	
Podiatry	Yes ☐	No ☐	
Continence Care	Yes ☐	No ☐	
Care contact (wheelchair / aids)	Yes ☐	No ☐	

(Please attach reports from the therapist currently involved in the care of the patient or arrange for them to be sent.)

24. Goals for rehabilitation

Goal identification; please provide details:

Standardised assessments / outcome measures used to identify goals

Type:	**Date:**	**Outcome:**

Patient's ability to actively carry over goals from therapy sessions and any barriers to this:

Form completed by:

Name:

Designation:

Contact details:

Signature:

Date:

Outcome:

Yes, referral accepted

No, referral rejected

If referral rejected, give reason: