

Bromley Community Neuro-

Rehab and Support Service

# Neuro-Rehabilitation (non-stroke) Referral Form Email: [bromh.bromleyhealthcarereferrals@nhs.net](mailto:bromh.bromleyhealthcarereferrals@nhs.net) Tel: 0208 2699826

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| 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** | | | | | |
| **Discharge date from hospital:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **At home at the above address** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | **Other:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consultant / referrer details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Surname:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Organisation name:** | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| General Practitioner details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Surname:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Surgery name:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Next of kin details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Title:** | |  | | | | | | | | | | | **First Name:** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Surname:** | | | | | | | | | | | | |  | | | | | | | | | | | |
| **Address (if different to patient’s):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone:** | | | | | | **(Home)** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **(Mobile)** | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **Relationship to patient:** | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary diagnosis:** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date of onset:** | | | | |  | | | | |
| **Date of surgery (if applicable):** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | **Surgical Procedure:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Secondary diagnosis:** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for referral | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intensive multidisciplinary rehabilitation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Disability management** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Summary of medical/surgical history | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Drug / alcohol use:** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **History of deliberate self-harm:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Previous physical and cognitive function:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **4.** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2.** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **5.** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3.** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **6.** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mobility and transfers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Transfers (check 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** | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision and hearing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | **Yes** | | | | | | | **No** | | | | | | | | **Comments / further details:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Visual problems:** | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hearing problems:** | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Communication and Swallowing problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Level of communication:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consistent yes/no responses** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | **Single word level** | | | | | | | | | | | |  | | | | | **Sentences** | | | | | | | | | | | | |  | | | **Full phrases** | | | | | | |  |
| **Swallowing problems:** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Behavioural / Cognitive problems |
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| Social situation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Lives alone** |  | | | | **Lives with:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **POC** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Does the patient have any carer roles?** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Home environment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of property** | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | |
| **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:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **(Please attach reports from the therapist currently involved in the care of the patient or arrange for them to be sent.)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Goals for rehabilitation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Goal identification; please provide details:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Standardised assessments / outcome measures used to identify goals** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type:** | | | | | | | | | | |  | | **Date:** | | | | |  | **Outcome:** | | | | | | | | | | | | |
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| **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:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |