

Bromley Community Neuro-

Rehab and Support Service

# Neuro-Rehabilitation (non-stroke) Referral FormEmail: 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 |
|  |
| **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:** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **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:** |  |