Saint Cyril's
Rehabilitation Unit

NEUROREHABILITATION SERVICE

INPATIENT REFERRAL FORM

Please Note: *This form must be completed even if a separate referral letter has been sent; the whole form needs to be completed in order for us to assess the patient's suitability for our service. Failure to complete will result in a referral being delayed.*

You can either e-mail this referral to deniseujvari@stgeorgehealthcaregroup.co.uk or fax it to Denise Ujvari: 01925 423307

Patient's Details

Hospital/ Current Location		Ward	
Hospital Telephone		Ward Phone	

Patient's Name:		D.O.B	
NHS Number		Hosp. Number	
ADDRESS:			
Telephone Number:			
GP Address: Telephone Number			
Funding Contact			
Address			
Key Contact			
Telephone Number			
Email			
Medical Consultant		Tel No / Bleep	

Relevant Contacts of person completing this form

Name:	
Position:	
Contact Details:	

<table>
<tr><td rowspan="1">Diagnosis/Presentation</td><td colspan="2"></td></tr>
<tr><td>Date of Onset</td><td colspan="2"></td></tr>
<tr><td>Other Diagnosis and Previous Medical History</td><td colspan="2"></td></tr>
<tr><td>Investigation Results</td><td colspan="2"></td></tr>
<tr><td rowspan="2">Allergies</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="2">Details:</td></tr>
<tr><td rowspan="2">Seizures</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="2">Details:</td></tr>
<tr><td>Drugs / Medication
Please indicate if able to self medicate</td><td colspan="2"></td></tr>
<tr><td>Reason for referral, expected outcomes and goals</td><td colspan="2"></td></tr>
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NURSING		
MRSA Status	Neg. Pos	
Continence	Urine Faecal Conveen Pad	
Skin Integrity	Pressure sores Yes No (Place, dressing, Vac therapy, TVN involvement) Pressure relieving mattress Yes No Details:…………………………………………………………………………… …………………………………………………………………………………… …………………………………………………………………………………… …………………………………………………………………………………… ……………………………………………………………………………………	
Nutrition	PEG – Yes No Videofluroscopy (date and results) ……………………………………………………………………………………	
Additional Support or Needs	1 to 1 Support required Yes No Any other …………………………………………………………………………………… ……………………………………………………………………………………	
Preferred Language		**Interpreter Required** Yes No
Please tick those which apply	Aphasia ☐	Dysarthria ☐

MOBILITY TRANSFERS			
Hoist	Assistance of 2 ☐	Assistance of 1 ☐	Independent ☐
Board	Assistance of 2 ☐	Assistance of 1 ☐	Independent ☐
ETAC	Assistance of 2 ☐	Assistance of 1 ☐	Independent ☐
Crouch transfer	Assistance of 2 ☐	Assistance of 1 ☐	Independent ☐
Bed to chair	Assistance of 2 ☐	Assistance of 1 ☐	Independent ☐
WC to chair	Assistance of 2 ☐	Assistance of 1 ☐	Independent ☐
Walking	Indoors outdoors Stairs With aid Assistance Required Details……………………………… Distance, meters……………………………		
Soft Tissue Shortening	Yes No Comment		
Wheelchair	**Type**: Large ☐ Separate cushion ☐ Postural Support ☐ **Propulsion**: Powered ☐ Attendant ☐ Self Propelling ☐		

COGNITION, BEHAVIOUR AND MENTAL HEALTH			
Behaviour	Yes	No	**Details:**
Physical Aggression	Yes	No	
Verbal Aggression	Yes	No	
Agitation	Yes	No	
Wandering	Yes	No	
Requires close supervision	Yes	No	
Disinihibition	Yes	No	
Psychiatric assessment? If "yes" – date:	Yes	No	**Date:**
Outcome, Please include a copy of last assessment			
History of mental health problems? If "yes" – details -			
Mental health service currently (or previously) involved. If "yes" – contact details -			