***REFERRALS TO REHABILITATION MEDICINE COMMUNITY NEURO-OUTREACH SERVICE***

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| Please read the Neuro-Outreach Pre-referral Document under Rehabilitation Medicine Community Neuro-Outreach Service on the following link <https://www.ulh.nhs.uk/services/specialist-rehabilitation/>  |  |
| I confirm that I have read the Neuro-Outreach Pre-referral Document |[ ]

***REFERRAL CRITERIA CHECKLIST*** Tick if yes:

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| The patient is registered with a **Lincolnshire GP** |[ ]
| The patient requires **specialist rehabilitation** for a **neurological condition (excluding stroke, FND and Parkinsons Disease/Parkinsonism -there are other community services to support with these).** |[ ]
| The patient has had either a **recent** neurological event/relapse or a **significant** change of circumstance |[ ]
| The patient is **medically stable** |[ ]
| The referral is based on **rehabilitation** need rather than **diagnosis**.  |[ ]
| The patient has **rehabilitation potential** with **clear, SMART, functional goals** already identified and demonstrates a commitment to achieve these. |[ ]
| The patient has **consented** to the referral or, in the case of individuals with severe cognitive deficit, referral is deemed to be in their **best interest** and consent has been gained from an appropriate source (e.g. appointee) |[ ]

***PATIENT DETAILS***

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| **First name(s):** | **Address:** |
| **Last name:** |
| **NHS number:**  |
| **Date of birth:** |
| **Gender:** Male🞏 Female 🞏 Other: |
| **Email:** | **Post code:** |
| **Home number:****Mobile number:**  | **1st language (if not English):** **Translator needed?** Yes [ ]  No [ ]   |
| **Next of Kin** *(Name, Relationship and Telephone):* |
| **Lasting power of attorney** *(Health and/or Welfare):* Yes [ ]  No [ ]  If yes, please provide details such as their name, relationship, telephone, and whether it is for health and/or welfare: |
| **Does the patient have any communication / information needs relating to a disability or sensory loss?** (*including people who have a learning disability, who are deaf, blind or deafblind, who have some hearing or visual loss, aphasia, autism or a mental health condition which affects their ability to communicate)* Yes [ ]  No [ ]  If yes, please provide further details of what they are: |
| **How does the patient prefer to be contacted?**Telephone [ ]  Email [ ]  Text message [ ]  Via a carer [ ]  If via a carer, please provide their name, relationship and telephone: |
| **GP Name, Practice and Address:****Has the GP been made aware of the referral?** Yes [ ]  No [ ]   |
| **Consultant Name and Address:****Has the Consultant been made aware of the referral?** Yes [ ]  No [ ]  *Please note we are unable to accept this referral if the patient’s GP or Consultant have not been made aware due to funding.* |
| **Is the patient under Rehabilitation Medicine?** Yes [ ]  No [ ]  *If no and the patient has been diagnosed with an acute neurological condition, please refer to Rehabilitation Medicine. This is important so that the patient will be followed up by a Rehabilitation Consultant.* |

***MEDICAL HISTORY***

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| **Primary Neurological Diagnosis:** | **Date of onset:** |
| **Recent Scan/investigation results:** |
| **Main diagnosis related impairments:** |
| **Current medication:**  |
| **Alerts/allergies:** |
| **Co-morbidities/past medical history** *(including Thyroid, Heart, Respiratory, Epilepsy, Arthritis, Diabetes, Surgery, Mental health background, Learning disability, Neurodiverse condition e.g. ADHD, Autism, Dyspraxia, Dyslexia):* |
| **DNACPR:** Yes [ ]  No [ ]  **RESPECT FORM:** Yes [ ]  No [ ]   |
| **Height:** |
| **Weight:** |

***REFERRAL DETAILS*** *[please note that if this information is not* ***clear******and fully completed*** *then we reserve the right to decline the referral and return the form]*

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| **Date of referral:** |
| **Referrer’s name:** |
| **Designation:** |
| **Organisation:** |
| **Telephone:** |
| **Email:** |
| **Referral reason:** *[why do you think this patient requires specialist, multidisciplinary team input from the Community Neuro-Outreach Rehab Team?]* |
| **Anticipated therapy requirement:** *[please tick all that apply and ensure clear reason for each discipline ticked]*Physiotherapy [ ]  Occupational Therapy [ ]  CNS Nurse [ ]  Dietitian [ ]  |
| **Patient’s SMART goals/expectations of treatment:****□ Physiotherapy**123**□ Occupational Therapy**123**□ CNS Nurse**123**□ Dietician**123 |
| **Patient’s social situation:** *(Please include the following: who the patient lives with, accommodation type, private/council/rented, employment status and job, caring responsibilities/dependents, relationships including intimacy, hobbies, benefits/finances, package of care/informal care, family/friend support and allocated social workers name and contact details if applicable, any specific information re: access (can the person open the door and keysafe no):* |
| **Patient’s current problems/functional level:** *[please tick all that apply and provide details]* |
| **PHYSICAL** (*mobility, movement, spasticity, weakness, pain, sensory - touch smell vision hearing tasting including management e.g. glasses or hearing aids, ataxia, balance, dizziness, fatigue, hormonal imbalances, speech, headaches, epilepsy, sexual dysfunction, bladder and bowels continence including management e.g. catheter*): Yes [ ]  No [ ]  If yes, please provide details: |
| **MOBILITY AND TRANSFERS** (*bed mobility, transfers, shower/bath transfers, indoor mobility, outdoor mobility, gait, aids, stairs, falls history, wheelchair/seating, driving*): Yes [ ]  No [ ]  If yes, please provide details: |
| **PERSONAL CARE** (*feeding/eating, dressing, washing, toileting/continence):* Yes [ ]  No [ ]  If yes, please provide details: |
| **SKIN INTEGRITY** (*any pressure sores or risk of pressure sore with details*):Yes [ ]  No [ ]  If yes, please provide details: |
| **DOMESTIC/COMMUNITY** (*meal preparation, housework/laundry, financial management, shopping, getting out and about)*Yes [ ]  No [ ]  If yes, please provide details: |
| **NUTRITION** (*swallowing difficulties, receiving alternative feeding e.g. PEG, type of diet and fluids, maintaining weight*):Yes [ ]  No [ ]  If yes, please provide details: |
| **COMMUNICATION** (*expressing self – can patient call for help, understanding others, reading and writing, aphasia, apraxia of speech, dysarthria, cognitive communication difficulties*):Yes [ ]  No [ ] If yes, please provide details: |
| **SOCIAL/BEHAVIOURAL** (*post-traumatic amnesia, disinhibition, impulsiveness, irritability, aggression, perseveration, egocentricity, personality change):*Yes [ ]  No [ ]  If yes, please provide details: |
| **MOOD/EMOTIONAL** (*depression/sadness, anxiety/worry, frustration, anger, feelings of loss, post-traumatic stress disorder, apathy, emotional lability, stress, issues with empathy):*Yes [ ]  No [ ]  If yes, please provide details: |
| **COGNITION** (*Difficulties with attention, concentration, making decisions, processing information, problems with memory, feeling motivated, language, reasoning, insight, executive dysfunction, mental capacity issues):*Yes [ ]  No [ ]  If yes, please provide details: |
| **CAPACITY** Yes [ ]  No [ ]  If no, please provide details of any capacity assessments:**MCA FORM:** Yes [ ]  No [ ]  **DoLS:** Yes [ ]  No [ ]   |
| **FATIGUE AND SLEEP:**Yes [ ]  No [ ]  If yes, please provide details: |
| **ANY OTHER INFORMATION** (if required): |
| **Has there been a recent change in the patient’s baseline functional level?** *(mobility, transfers, personal care, skin integrity, domestic/community, social/behavioural)*Yes [ ]  No [ ]  If Yes, please give details such as previous functional level including approximate date: |

***SUPPORTING INFORMATION*** *[please tick all that apply]*

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| **Is patient currently in hospital, or had a recent hospital admission?** Yes [ ]  No [ ]  If Yes, please provide hospital name, ward name, planned or actual discharge date:Please also provide a brief summary of input patient has received to date:If the patient is currently in hospital, please liaise with the Outreach team to ensure an effective transition into the community. |

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| **Is patient able to attend an outpatient setting?** Yes [ ]  No [ ]  | **Any special requirements?**Wheelchair [ ]  Transport [ ]  Escort [ ]  Assistance with personal care [ ]  Other:  |

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| **Are there any other services involved or planned?** Yes [ ]  No [ ] If Yes, please provide details of service and named contact(s): |

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| **Are there any known risk(s) to lone workers associated with this patient or their home?***(Property e.g. buildings and access in disrepair, unsanitary conditions, infestation, aggressive animals, remoteness of the property, poor accessibility for car parking, poor mobile signal, domestic violence, drug/alcohol abuse, Suicide/self harm, Harm to/from others, infectious disease, known to other services/organisations e.g. probation, social services)*Yes [ ]  No [ ]  If Yes, please provide details of risk and suggested management plan: |

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| **Any safeguarding concerns raised?**Yes [ ]  No [ ]  If Yes, please provide details of risk and suggested management plan: |

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| Please return your completed form to **ulth.referralsneurooutreach@nhs.net** |

*Where possible, please include additional information such as discharge reports and results of investigations – thank you.*

**OFFICE USE:**

**DATE RECEIVED: LOCALITY: TRIAGE DATE: ACCEPT:**