

### Referral Form

|                                    |                             |                          |
|------------------------------------|-----------------------------|--------------------------|
| <b>Name and title of referrer:</b> | <b>Contact no:</b>          | <b>NHS Number:</b>       |
| <b>Name of client:</b>             | <b>DOB:</b>                 | <b>Ward/Hospital:</b>    |
| <b>Diagnosis:</b>                  | <b>Reason for referral:</b> | <b>Unit Referred to:</b> |

|                   |
|-------------------|
| Home address:     |
| Brief History:    |
| Medication:       |
| Known allergies:  |
| Family situation: |
| Religion:         |

**Disciplines involved in current treatment:**

|               |  |                 |
|---------------|--|-----------------|
| Nursing staff | Number of staff required to carry out care | 1, 2, 3 or more |
|               | Skin integrity - pressure area             | Yes / No        |
|               | Tracheostomy                               | Yes / No        |

|                      |                                |  |
|----------------------|--------------------------------|--|
|                      | O2 therapy required            | Yes / No                                       |
|                      | Nutrition                      | PEG<br>Modified diet<br>Normal                 |
|                      | Transfers                      | Independently<br>Assistance of 1 or 2<br>Hoist |
|                      | Continence                     | Continent<br>Catheter<br>Bowel regimen         |
|                      |                                |  |
| Infection control    | Recent episodes of loose stool | Yes / No                                       |
|                      | Any history of MRSA            | Yes / No If Yes, where                         |
|                      | Any recent flu-like symptoms   | Yes / No                                       |
|                      |                                |  |
| Psychology           | Orientation                    | Time Y / N<br>Place Y / N<br>People Y / N      |
|                      | Mood                           |  |
|                      | Unwanted behaviour             | Yes / No<br>If Yes, please specify:            |
|                      |                                |  |
| Psychiatry           | Under section                  | Yes / No                                       |
|                      |                                |  |
| Occupational therapy | Washing and dressing           | independent<br>with assistance of 1 or 2       |
|                      | Feeding                        | independent<br>with assistance of 1            |

|                             |   |   |
|-----------------------------|---|---|
| Physiotherapy               | Mobility  | independent<br>with aids<br>with assistance<br>unable |
| SALT                        | Swallowing difficulties                                   | Yes / No  |
|                             | Communication difficulties                                | Yes / No<br>If Yes, please specify:                   |
| Specialist equipment needs: | If Yes please specify what they are and if they have them |   |
|                             | Wheelchair  | Yes / No  |
|                             | Bed / mattress  | Yes / No  |
|                             | Communication aids  | Yes / No  |
|                             | Splints   | Yes / No  |
| Additional considerations:  | If Yes, please specify                                    | Yes / No  |
|                             | Visual / perceptual difficulties                          | Yes / No  |
|                             | Spasticity  | Yes / No  |
|                             | Risk of absconding  | Yes / No  |
|                             | Inappropriate behaviour                                   | Yes / No  |
|                             | Aggression<br>If Yes                                      | Yes/ No<br>Verbal / Physical / Both                   |
|                             | Require specialing  | Yes / No  |
| Funding agreed              |   | Yes / No  |