



Royal Hospital for
Neuro-disability

A national medical charity
Registered Charity No. 205907

APPLICATION FOR ADMISSION

The information requested is essential in helping us decide on the appropriateness for acceptance of your patient to the Royal Hospital for Neuro-disability, and the unit that will best meet their needs.

Please complete the form in its entirety as incomplete information may result in delay.

Please tick the box to indicate the type of service you are seeking (see accompanying information sheets for further details).

- Assessment, rehabilitation and / or disability management of neurologically disabled person
- Neuro-behavioural Rehabilitation Unit
- Transitional Living Unit
- Huntington's Disease Unit
- Long Term Care / Disability Management
- Ventilator Unit
- Respite Care
- Community Neuro-disability Unit (Day Service)

In addition to the information requested in this form we require a detailed medical report outlining the clinical status of the patient. It would also be most helpful to provide copies of any recent therapy reports that are available.

Please return the application form to:
Admissions Office
The Royal Hospital for Neuro-disability
West Hill
Putney
London, SW15 3SW

Tel: 020 8780 4513
Safe Haven Fax: 020 8780 4511
Email: admissions@rhn.org.uk
Website: www.rhn.org.uk

PATIENT'S PERSONAL DETAILS

First Name(s) _____ Surname _____

Date of Birth _____ Gender _____ Marital Status _____

Nationality _____ First Language _____

Home Address _____

_____ Post Code _____ Tel: _____

Present Address (e.g. Ward and Hospital address) _____

Tel. Number _____ Fax Number _____

Occupation _____ Religion _____

NEXT OF KIN

Name _____ Address _____

_____ Tel: _____

Relationship _____

Other relevant family contacts _____

SOCIAL SECURITY BENEFITS (please list) _____

_____ National Insurance No. _____

GP DETAILS

Name _____ Address _____

_____ Tel: _____

GP's Primary Care Trust _____

Please advise the Admissions Office if there is a requirement for the patient guide and future patient/relative/carer information to be provided in an alternative format or language.

CLINICAL INFORMATION

Diagnosis _____ ICD 10 Code _____

Date or time since onset of disorder or injury _____

Patient's NHS number _____

Summary of medical history:

In addition, please attach a detailed medical report outlining the clinical status of the patient.

Is this patient being held under the Mental Health Act: Yes / No

If yes is the patient being held as a voluntary patient / formal / informal (please indicate which)

Medical Disorders: (please tick)

- Diabetes melitus
- Heart failure
- Hypertension
- Epilepsy
- MRSA
- AIDS
- Known HIV positive
- Known hepatitis
- Other infectious or communicable disease

Medical/Surgical Procedures:

- Gastrostomy tube
- Nasogastric tube
- Tracheostomy tube
- Ventricular shunt
- Urinary catheter
- Other procedure (state)

PHYSICAL MANAGEMENT

Mobility

Wheelchair (type)

If wheelchair provided, by which wheelchair service? _____

Contractures (where and degree) _____

Dependency level _____

Pressure sore (s) _____

Current weight _____

SENSORY / COGNITIVE / BEHAVIOURAL

Visual Impairment _____ Hearing impairment _____

Mental State (describe) _____

Behaviour Disorder (describe) _____

SPECIAL DIETS OR FOOD PREPARATION

FUNDING

Please give details of the Primary Care Trust or Local Authority, Medical or Insurance Company or individual accepting, or requested to accept responsibility for funding this applicant's placement at the Royal Hospital for Neuro-disability

CONTACTS

Please complete to enable us to contact relevant people for further information should it be required.

Consultant _____

Ward Sister / Community Nurse _____

Social Worker _____

Occupational Therapist _____

Physiotherapist _____

Speech Therapist _____

Psychologist _____

Dietitian _____

Referring Doctor _____

Person completing the form (**Name and position**) _____

Signature _____

Date _____