**REFERRAL FORM**

**REASON FOR REFERRAL:**

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| **SERVICE DESCRIPTIONS:** | ***Please tick relevant box and provide the reason for the referral below:*** |
| **Huntington’s Disease Service**   * **Short term placement** * **Long term placement** |  |
| **Neuro-behavioural Service**   * **Short term placement** * **Long term placement** |  |
| **Specialist Nursing Home**   * **Short term placement** * **Long term placement** * **Slow stream rehabilitation** |  |
| **Ventilator Service** |  |
| **Young Adult Service** |  |

**DETAILS OF INDIVIDUAL COMPLETING REFERRAL:**

|  |  |
| --- | --- |
| **Name** |  |
| **Role** |  |
| **Referring Organisation** |  |
| **Telephone number** |  |
| **Email address** |  |

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| Please email to: [TRHFN.Admissions@nhs.net](mailto:TRHFN.Admissions@nhs.net)  OR CALL: 020 8780 4313 |

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| **CLIENT DETAILS** | | | | | |
| **Client’s FIRST Name** |  | | | **Client’s SURNAME** |  |
| **Client’s Home**  **Address, Postcode and Telephone Number** |  | | | **NHS Number** |  |
| **Gender** |  |
| **Language** |  |
| **Date of Birth** |  | | | **Interpreter required?** | YES/NO |
| **Current Location and Telephone Number** |  | | | | |
| **Next of Kin**  **Or**  **Adult Representative**  **Details** | **Name** | |  | | |
| **Address** | |  | | |
| **Telephone Number** | |  | | |
| **Email** | |  | | |
| **Relationship** | |  | | |
| **Client’s Current GP** | **GP Name** |  | | | |
| **Surgery** |  | | | |
| **Telephone Number** |  | | | |
|  | | | | | |
| **Diagnosis** |  | | | | |
| **Date of Injury/Onset** |  | | | | |
| **Summary of Medical History** |  | | | | |
| **Past Medical History** |  | | | | |
| **Outstanding investigations / Follow-up(s)** |  | | | | |
| **Current medication** | *Please list or attach medication list:* | | | | |
| **Drug/Alcohol Use** |  | | | | |
| **History of Self-harm** |  | | | | |
| **Level of Function Prior to Incident/Injury** |  | | | | |
| **Social History** |  | | | | |
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| **Mental Health Act (MHA)** | Is the Client in current placement under the MHA? **YES / NO** | | | | |
| **Capacity** | *Please provide details regarding Client’s capacity:*  Does the client have a DoLs in place in their current placement? **YES/NO**  Does the client have the mental capacity to make their own decision about the referral to RHN? **YES / NO**  Has the Client agreed to the referral to the RHN? **YES / NO / BEST INTERESTS** | | | | |
| **Best Interests:** | Is a Best Interests Decision required over placement? **YES / NO**  Has this meeting taken place? **YES / NO / N/A**  Date of meeting and outcome: | | | | |
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| **CURRENT CARE NEEDS** *Please tick all that apply* | | |
| **Breathing** | Self-ventilating  Tracheostomy  NIV  Bipap / CPAP  Full ventilation  Oxygen requirements  Suctioning | *Additional details:* |
| **Nutrition and Hydration** | Dysphagia  Oral diet/Modified oral diet  Nasogastric feeding  Gastrostomy (PEG)  Jejunostomy  Height:…………… m  Weight…………… kg  BMI…………. | *Additional details:* |
| **Continence** | Continent  Urinary incontinence  Urinary catheter  Faecal incontinence | *Additional details:* |
| **Skin** | Pressure sore(s)  Broken skin  Skin intact  Other skin condition | *Additional details:* |
| **Mobility** | **Transfers**  Independent  Assist of one  Assist of two  More than assist of two  Hoist  Other (*provide details*)  **Walking**  Independent  Assist of one  Assist of two  Other (*provide details*)  **Wheelchair**  Independent  Pushed by attendant  Loan wheelchair  Own wheelchair  **How arms/legs/body moves**  Contractures  Passive/spontaneous movement only  Splints/orthotics  Other (*provide details*) | *Additional details:* |
| **Personal Care and ADLs** | Independent  Assist of one  Assist of two  More than assist of two  Any special equipment  *(give details)* | *Additional details:* |
| **Cognition and Communication** | **Level of communication**  Unable to communicate  Gesture/body language  Consistent yes/no responses  Single word level  Full phrases  Sentence level  Other *(give details)*  **Language**  Dysphasia  Dysarthria  Other *(give details)*  **Cognition**  Cognitive difficulties  Perceptual difficulties  Ability to learn  Other *(give details)*  **Is the client in a PDOC?**  **Yes**  **No**  *(If ‘yes’ provide details)* | *Additional details:* |
| **Psychological and emotional needs** | Low mood  Depression  Other *(give details)* | *Additional details:* |
| **Behaviour** | Agitation  Harm to self/others  Verbal aggression  Physical aggression  Wandering  Exit seeking  Sexual disinhibition  Pulling at tubes  Declining medication  Other *(give details)* | *Additional details:* |
| **Medication and symptom control** | Is medication taken:  Orally  PEG/RIG  Depot injection  Other *(give details)*  Does client experience pain?  **Yes**  **No**  *(If ‘yes’ provide details)* | *Additional details:* |
| **Altered States of Consciousness (ASC)** | Seizures  Other *(give details)* | *Additional details:* |
| **Other care needs not identified above** | Renal dialysis  Intrathecal baclofen pump  Laryngectomy  Specialised equipment  Other (*include details*) | *Additional details:* |
| **Aims/goals of admission**  *(if appropriate)* | *Please list any aims/goals of admission:* | |
| **Funding details**  *Please provide details of funding authority (health or local authority), Medical or Insurance Company, or individual accepting, or requested to accept responsibility for funding this client’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.*  *Include email addresses and phone numbers as appropriate.* | **Consultant:**  **Referring Doctor:**  **Ward sister/Community nurse:**  **Social worker:**  **Occupational Therapist:**  **Physiotherapist:**  **Speech & Language Therapist:**  **Psychologist:**  **Dietitian:** | |