**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**
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| **Neuro-behavioural Service*** **Short term placement**
* **Long term placement**
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| **Specialist Nursing Home*** **Short term placement**
* **Long term placement**
* **Slow stream rehabilitation**
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| **Ventilator Service** |  |
| **Young Adult Service** |  |

**DETAILS OF INDIVIDUAL COMPLETING REFERRAL:**

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

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| Please email to: TRHFN.Admissions@nhs.netOR 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** |  |
|  |
| **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-ventilatingTracheostomyNIVBipap / CPAPFull ventilationOxygen requirementsSuctioning | *Additional details:* |
| **Nutrition and Hydration** | DysphagiaOral diet/Modified oral dietNasogastric feedingGastrostomy (PEG) JejunostomyHeight:…………… mWeight…………… kgBMI…………. | *Additional details:* |
| **Continence** | ContinentUrinary incontinence Urinary catheterFaecal incontinence | *Additional details:* |
| **Skin** | Pressure sore(s) Broken skinSkin intactOther skin condition | *Additional details:* |
| **Mobility** | **Transfers**IndependentAssist of oneAssist of twoMore than assist of twoHoistOther (*provide details*)**Walking**IndependentAssist of oneAssist of twoOther (*provide details*) **Wheelchair**Independent Pushed by attendantLoan wheelchairOwn wheelchair**How arms/legs/body moves**ContracturesPassive/spontaneous movement onlySplints/orthoticsOther (*provide details*) | *Additional details:* |
| **Personal Care and ADLs** | Independent Assist of oneAssist of twoMore than assist of twoAny special equipment*(give details)* | *Additional details:* |
| **Cognition and Communication** | **Level of communication**Unable to communicateGesture/body languageConsistent yes/no responsesSingle word levelFull phrasesSentence level Other *(give details)***Language**DysphasiaDysarthriaOther *(give details)***Cognition**Cognitive difficultiesPerceptual difficultiesAbility to learnOther *(give details)***Is the client in a PDOC?****Yes****No***(If ‘yes’ provide details)* | *Additional details:* |
| **Psychological and emotional needs** | Low moodDepressionOther *(give details)*  | *Additional details:* |
| **Behaviour** | AgitationHarm to self/othersVerbal aggressionPhysical aggressionWanderingExit seekingSexual disinhibitionPulling at tubesDeclining medicationOther *(give details)* | *Additional details:* |
| **Medication and symptom control** | Is medication taken:Orally PEG/RIGDepot injectionOther *(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 dialysisIntrathecal baclofen pumpLaryngectomySpecialised equipmentOther (*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:** |