Royal Hospital for Neuro-disability

REFERRAL FORM

SERVICES:	*Please tick relevant box and provide the reason for the referral below:*
Huntington's Disease Unit - **Short term placement** - **Long term placement**	☐ ☐
Neuro-behavioural Unit - **Short term placement** - **Long term placement**	☐ ☐
Specialist Nursing Home - **Short term placement** - **Long term placement**	☐ ☐
Ventilator Unit - **Short term placement** - **Long term placement**	☐ ☐
Young Adult Unit	☐

DETAILS OF INDIVIDUAL COMPLETING REFERRAL:

Name	
Role	
Referring organisation	
Telephone number	
Email address	

Please email to: TRHFN.Admissions@nhs.net **or call:** 020 8780 4513

Please send the following supporting documents with the referral:

- Treatment Escalation Plan (TEP)
- Resuscitation status
- Current medication list
- COVID-19 infection and vaccination record
- For neuro-behavioural referrals: ABC/ behavioural recording charts, Datix/ incident reports, behavioural guidelines, psychology/ psychiatry reports as available

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PERSONAL DETAILS			
FIRST NAME		SURNAME	
Home address and postcode Home phone number		Gender	
		Religion	
		Ethnicity	
Date of birth		Language	
NHS number		Interpreter required?	YES/NO
Current location and telephone number			
Next of Kin OR Paid relevant persons representative OR adult representative details	Name		
	Address		
	Telephone number		
	Email		
	Relationship		
Current GP	GP name		
	Surgery		
	Telephone number		

INJURY/ DIAGNOSIS DETAILS	
Injury/ diagnosis	
Date of injury/ onset	
Background of current injury/ diagnosis	
Past medical history/ co-morbidities	
Outstanding investigations OR follow-up	
Drug/alcohol use	
History of self-harm	
Level of function prior to injury/ diagnosis	
Social History	

CAPACITY DETAILS	
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 referral to RHN? **YES / NO** Has the client agreed to the referral to the RHN? **YES / NO / BEST INTERESTS**
Best Interests:	Is a best interest's decision required for placement? **YES / NO**

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	Has this meeting taken place? **YES / NO / NOT APPLICABLE** Date of meeting and outcome: Has withdrawal of nutrition and hydration been discussed? (if appropriate) **YES / NO / NOT APPLICABLE** Date of discussion and outcome:

CURRENT CARE NEEDS	*Please tick all that apply*	*Additional details*
Breathing	Self-ventilating ☐ Tracheostomy ☐ Suctioning (type/ freq.) ☐ NIV ☐ BIPAP/ CPAP ☐ Full ventilation ☐ Oxygen requirements ☐ Airvo ☐ Cough assist ☐	*Include details of: other trache equip/ devices, potential to wean, OWV use.*
Nutrition & hydration	Dysphagia ☐ Oral diet/ modified diet ☐ Nasogastric feeding ☐ Gastrostomy (PEG) ☐ RIG ☐ Jejunostomy ☐ Height: …… m Weight: …… kg BMI: ……	*Include details of: enteral feeding site, IDDSI levels, level of assistance.*
Continence	Continent ☐ Urinary incontinence ☐ Urinary catheter ☐ Faecal incontinence ☐ Continence pads ☐	*Include details of: awareness of toileting needs, re-training, TWOC.*
Skin	Pressure sore (s) ☐ Broken skin ☐ Skin intact ☐ Other skin conditions ☐	*Include details of: wound grade, dressings, creams, treatment plan.*
Mobility	**Transfers** Independent ☐ Assist of one ☐ Assist of two ☐ More than assist of two ☐ Hoist ☐ Other (*provide details*) ☐ **Walking** Independent ☐ Assist of one ☐	*Include details of: therapy compliance, amount of current input, falls risk, spasticity management plan*

	Assist of two ☐ Other (*provide details*) ☐ **Wheelchair** Independent ☐ Attendant propelled ☐ Loan wheelchair ☐ Own wheelchair ☐ **How arms/legs/body moves** Contractures ☐ Passive/spontaneous movement only ☐ Splints/orthotics ☐ Other (*provide details*) ☐	
Personal care & ADLs	Independent ☐ Assist of one ☐ Assist of two ☐ More than assist of two ☐ Any special equipment ☐ *(give details)*	*Include details of: potential to increase independence/ reduce assistance*
Cognition & communication	**Level of communication** Unable to communicate ☐ Gesture/body language ☐ Consistent yes/no ☐ 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)*	*Include details of: PDOC diagnosis, assessments completed*
Psychological & emotional needs	Low mood ☐ Depression ☐ Other *(give details)* ☐	*Include details of: level of support, medications required*
Behaviour	Agitation ☐ Harm to self/others ☐ Verbal aggression ☐ Physical aggression ☐	*Include details of: 1-1/ 2-1 support, sedation, frequency, strategies used.*

	Wandering ☐ Exit seeking ☐ Sexual disinhibition ☐ Pulling at tubes ☐ Declining medication ☐ Other *(give details)* ☐	
Medication & symptom control	Is medication taken: Orally ☐ PEG/RIG ☐ Depot injection ☐ Other *(give details)* ☐ Does client experience pain? **Yes** ☐ **No** ☐ *(If 'yes' provide details)*	*Include details of: PRN medication*
Altered states of consciousness (ASC)	Seizures ☐ Other *(give details)* ☐	
Other care needs not identified above	Renal dialysis ☐ Intrathecal baclofen pump ☐ Laryngectomy ☐ Specialised equipment ☐ Other (*include details*) ☐	
ADMISSION DETAILS		
Aims/ goals of admission *(if appropriate)*		
Funding details *Please provide details of funding authority (health or local authority), medical/ insurance company, individual accepting, or requested to accept responsibility for funding this placement.*		
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:**	

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	Speech & Language therapist: **Psychologist:** **Dietitian:** **Known to any other teams** (i.e. mental health, PMLD, community?) **YES / NO** Details: