Peamount Healthcare | Athshlánú Rehabilitation | Cúram Cónaithe Residential | Comhphobail Community

Attach Client addressograph label or complete:

Name: ____

DOB: ________________ MRN: __________________

Address: _____________________________________

____

____

PEAMOUNT HEALTHCARE REHABILITATION SERVICE APPLICATION FORM

Applications will only be considered if mandatory Sections A-E are completed in full.

Checklist	**Tick**
Mandatory Sections A-E Completed	
Medical Details: • **Copy of Kardex** • **Copy of Patient's Initial Admission Note** • **Copy of Consultant Geriatricians Assessment:** This needs to include notes indicating patient is suitable for Peamount and patient is agreeable to referral.	
Allied Health Professionals Sections F-J Completed Place "not indicated" in section if AHP has not been involved with patient	
Tick this box when patient has: • Been provided with Peamount's Rehabilitation Leaflet • Has been made aware of possibility transfer back to acute hospital	

All referral forms to be emailed to RehabGroup@peamount.ie

Section A: GENERAL DETAILS

Attach Client addressograph label or complete:

Name: ______________________________________

DOB: _______________ MRN: _________________

Address: ____________________________________

____

____

Applicant Tel No: __________________________________

Medical Card: YES ☐ NO ☐

If YES, please give no: ___________________________

Health Insurance: YES ☐ NO ☐

If YES, Insurer: _________________________________

Insurance Policy No: _____________________________

Hospital/GP: ___________________________________ **Referring Consultant**: _______________________________

Date of Hospital Admission: _____ / _____ / _____ **Ward**: _______________________ **Tel**: ____________________

Is Applicant aware of this application: YES ☐ NO ☐

Family Contact: ____ **Tel**:_____________________

Relationship to Applicant: ____

Address: ____

Section B: NURSING

Pressure Sore Assessment Tool Used: ____ Score: ____________

Pressure Sore: YES ☐ NO ☐ If YES, grade: ________ Location: ____
(European Pressure Ulcer Advisory Panel Grading System)

Pressure Relieving Equipment: ____

History of Falls: YES ☐ NO ☐

Sleeping: ____

Wound: YES ☐ NO ☐ If YES, location: ____

Continent ☐ **Incontinent**: urine ☐ faeces ☐ both ☐ **U/C**: ☐

Pain: YES ☐ NO ☐ If YES, location: ____ Pain scale: _____ / 10

Completed by (BLOCK CAPS): ____ Date: ____ / ____ / ____

Signature: ____ Tel: __________________________________

Section C: Medical

Please fill out this information in full as it is used to decide appropriateness of patient transfer and will delay transfer if not completed in full. Peamount has no access to external bloods, radiology or medical notes so all information is required to continue patient care safely and efficiently.

Presenting medical complaint (eg. Stroke with aphasia/ Fall due to OH with NOF#/etc)

____

Other medical history (Please include ALL medical conditions if no underlying conditions state this)

Issues whilst inpatient and management of this (eg. HAP / hypokalaemia/ C Diff etc)

____
____
____
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____

Investigations carried out whilst an inpatient

Radiology

Date	Scan	Result

Bloods – Please list here any abnormal bloods.

Other inpatient investigations (endoscopy) **or consults** (reason for consult and outcome)

____
____
____
____
____
____
____
____
____

Outstanding investigations and appointments

____
____
____
____

Cognitive Assessment Completed Yes No If yes, Result and date performed: ________________________

Living situation: Lives alone ____ With spouse_____ With family_______ In LTC ________

HCP (Please specify level) _________________________ No HCP ______________

	Prior to admission	Current Status
Mobility		
Personal ADLs		
Swallow function/ Diet		
Speech function		

Geriatrician review ____ Date _________________

Medications

Medication	**Dose**	**Frequency**	**Route**	**Duration**	**Medication**	**Dose**	**Frequency**	**Duration**	**Route**

Please list here any medications altered during admission and reason for. If no alterations made please state this.

____

____

Form filled by _______________Role ___________ Consultant _____________ Date____________

Please attach copy of patients initial admission note, copy of cognitive assessment and copy of geriatricians assessment. Please complete Section D: Letter of Undertaking to Re-admit to Referring Hospital.

Peamount Healthcare | Athshlánú Rehabilitation | Cúram Cónaithe Residential | Comhphobail Community

Section D: Letter of Undertaking to Re-admit to Referring Hospital

Prof T Coughlan
Age Related Rehabilitation Unit
Peamount Healthcare
Newcastle
Co Dublin

Date: _________________

Attach addressograph label or complete the following
Client name: ___________________________
DOB: ____________ MRN: ______________
Address: _____________________________
____
____

Dear Prof Coughlan ________________________,

I, ____ **(BLOCK CAPITALS)**, wish to confirm that I have spoken with Dr / Mr / Prof _________________________________ **(BLOCK CAPITALS)**, and s/he has given an undertaking to re-admit the above named patient to ________________________ Hospital should it be required.

Yours sincerely,

____________________________________ Tel: _____________________ Bleep No: _______

Consultant ☐ Sp R ☐ Reg ☐ SHO ☐ Intern ☐ *(tick as appropriate)*

Applicant's name: ____ **DoB**: ___________________

Section E: Infection Control

*Does the patient have a history of **any** Multidug resistant organisms (including previous admissions)?* e.g MRSA,ESBL,VRE,CRE CLOSTRIDIUM DIFFICILE	YES OR NO If the answer to this question is YES give details below of the type of organism, date isolated & sample site.
PATIENTS NAME:	
DOB:	
MRN :	

MDR0 DETAILS		
Name of organism	Date isolated	Sample site

CRE SCREENING REQUIREMENTS	
Has the patient ever tested positive for CRE ? YES OR NO	If YES give details of date of positive result and sample site.
CRE contact ? YES OR NO	If YES give details of date of exposure and any CRE screens results since exposure

PATIENT PLACEMENT	
What type of IP&C precautions are in place **Answer this for all patients**	Standard Transmission based (if YES what type?)
Where is the patient accommodated at present	e.g single room or multi-bedded room

Signature:________________________ Grade:_______________ Date:____________

Section F: CLINICAL NUTRITION & DIETETICS

Current Weight: _________(date: _____) **Height**: ______ **Admission Weight**: ___________(date:_____)

Usual Weight: ____________ **BMI:** _____________ **Weight Loss:** (kg / %)_________________

Special Diet Required *(if applicable)*: ____

Nutrition Support: Supplements ☐ List:____

NG feeding ☐ PEG/JEG feeding ☐

Please note, enteral feeding tubes only accepted with prior agreement from the dietetics department

Completed by (BLOCK CAPS): _______________________________ Date: ____ / ____ / ____

Signature: _______________________________ Tel: _______________________

Please provide detailed handover as require for any patients to 01 6010300 ext:412.

Section G: SOCIAL WORK

Applicant's name: _______________________________ **DoB**: ___________________

Key family contact: _______________________________ **Tel**: ___________________

Family Composition: ____

Family involved in care: YES ☐ NO ☐

If YES, state extent: ____

____

Applicant's understanding of rehabilitation: ____

____

Key reason for Social Work involvement to date: ____

____

Community services involved prior to admission: YES ☐ NO ☐

If YES tick all that apply: PHN ☐ MOW ☐ HH ☐ HCA ☐ GP ☐ Day Care ☐
Other ☐: _______________________________

Identified Discharge Destination: Own home ☐ Family member's home ☐ Elsewhere (please give details) ☐: ______________________ ___________________________________	**HSE Home Care Package**: YES ☐ NO ☐ **Application being made**: YES ☐ NO ☐
	Accommodation: Private ☐ Local Authority ☐ Rented ☐ Single storey ☐ 2 storey ☐ Lift ☐

Completed by (BLOCK CAPS): _______________________________ Date: ____ / ____ / ____

Signature: _______________________________ Tel: _______________________

Section H: OCCUPATIONAL THERAPY

Applicant's name: ____**DOB**: ____________________

Home Environment:____

Social Situation/Supports: ____

Home visit carried out: YES ☐ NO ☐ If YES, date: ____ / ____ / ____

Community OT referral: YES ☐ NO ☐ If YES, date: ____ / ____ / ____

Activities of Daily Living:

Please indicate level of assistance required by this person at baseline and their current level using the abbreviations listed. Please also document manual handling equipment used; e.g.: Sara Stedy, RZF

Indep. = Independent
S/V= Supervision
AX2=Assistance of two required
SS= Sara Stedy
Min AX1= Minimal assistance of one person
Mod AX1= Moderate assistance of one person
Max AX1= Maximum assistance of one person

	Baseline Level	**Current Rating**		**Baseline Level**	**Current Rating**
Feeding			Mobility		
Grooming			**Transfers:**		
Lower body dressing			Bed to chair		
Upper body dressing			Toilet		
Washing/bathing			Bath/shower		
Toileting					

Seating: ____

Upper Limb Status:____

Vision/ Perception:____

____

Cognition:

- Please give details of baseline cognition: ____
- Please describe current cognition:____

  ____

  ____
- Have any formal cognitive or functional cognitive assessments been completed? If so, please give details and attach report forms: ____

  ____
- Are there any cognitive issues that may impact on rehab? ____________________________________

  ____

Further OT rehabilitation goals:

____

____

Completed by (BLOCK CAPS)______________________________ Email: ______________________

Signature: __________________________ Date: __ / __ / __ Tel: ________________ Bleep #____

Please attach/forward OT report to OTGroup@peamount.ie

Section I: SPEECH AND LANGUAGE THERAPY

Applicant's name: ____ **DoB**: ____________________

SLT Diagnoses *(please tick all that apply):*

- ☐ Dysarthria
- ☐ Dyspraxia
- ☐ Dysfluency
- ☐ Dysphonia
- ☐ Receptive Language Impairment
- ☐ Expressive Language Impairment
- ☐ Cognitive-linguistic Impairment
- ☐ Pragmatic Disorder
- ☐ Dysphagia
- ☐ Other:_______________
  ____

SUMMARY OF SLT INTERVENTIONS
(please include outcome measures where possible)

	FEEDING, EATING, DRINKING, AND SWALLOWING STATUS	COMMUNICATION STATUS
At SLT initial ax Date: ______________		
At SLT review Date: ______________		
At SLT discharge Date: ______________		
Current Recommendations		
Goals for rehabilitation		

Other relevant information e.g. sensory deficits, social participation, motivation:
____
____
____
____

Completed by (BLOCK CAPS): ____ Date: ____ / ____ / ____

Signature: ____ Tel: ______________________________

Please attach/forward SLT report to sltgroup@peamount.ie

Section J: PHYSIOTHERAPY

Applicant's name: ____ **DoB**: ____________________

Physiotherapy treatment commenced on: ____ / ____ / ____

Main Physical Problems: ____

____

Mobility/Transfers:

	Baseline Status	**Current Status**
Bed mobility		
Transfers		
Mobility		
Stairs		

	Berg	**EMS**
Admission		
Discharge		

Treatment to date:

____

____

Any other relevant information e.g. splints, walking frame, stick:

____

____

Any major issues of note or Barriers to Rehab e.g. behavior that challenges, family relationships:

____

____

Goals for Physiotherapy:

____

____

Completed by (BLOCK CAPS): ____ Date: ____ / ____ / ____

Signature: ____ Tel: ______________________________

Please attach/forward Physiotherapy report to physiogroup@peamount.ie