Peamount Neuro Rehabilitation Referral Form

Please complete this form by ticking the appropriate boxes or by writing your response in space provided. Incomplete information may unnecessarily result in a lower priority rating and a longer waiting time for the person referred.

Completed referral form to be sent to: neurorehab@peamount.ie

Personal Details

Name		Date of Referral		
MRN		Referring Hospital		
DOB		Referring Consultant		
Home phone No		Speciality		
Mobile No		Contact No		
Address		GP Name, Address and Contact No		
Family Contact / NOK Name & Phone No		Consent (please circle)	Patient	Family Contact/NOK

Is an interpreter required?		Y	N	Medical Card and/or other benefits				Y	N
Ethnicity				Patient Current Location (including Unit)					
Medical Card	Eligible	Y	N	Applied	Y	N	Approved	Y	N

SECTION 1: TO BE COMPLETED BY MEDICAL

Details of injury/illness

Date of onset:

Details:

Relevant Investigations and/or Surgical Interventions (please include blood/scan results)

Current Medications (include dosages and allergies where known)

Other relevant Medical History

Summary of Current Impairments/Function							
Motor Loss		**Sensory Loss**		**Vision**		**Muscle Tone**	
Yes	No	Yes	No	Intact	Impaired	Intact	Impaired

Behaviour		**Cognition**		**Mood**	
Normal	Impaired	Normal	Impaired	Normal	Impaired

Respiratory	Oxygen Support	Yes	No	Type	

Completion of Medical Section:

Print Name: _____ **Signature: _____**

Role (please circle): Intern SHO Registrar Consultant

SECTION 2: TO BE COMPLETED BY NURSING

	Bladder	**Bowel**	**Skin**
Continence and Skin	Catheter Yes ☐ No ☐ Independent with: Toilet/Commode/Urinal ☐ Requires Assistance: Assist + 1 ☐ Assist + 2 ☐	Independent with: Toilet/Commode ☐ Requires Assistance: Assist + 1 ☐ Assist + 2 ☐ Bowel Function: Frequency per wk _____ Stool Type: _____	Norton Score: Pressure relieving equipment: Pressure Ulcers/Wound: Yes ☐ No ☐ Grade: Location:

Mealtimes	Assistance Required with meals: Yes ☐ No ☐	Give Details:
	Cultural Dietery Requirements Yes ☐ No ☐	If yes, give details:
Mood/Behaviour	Normal ☐ Impaired ☐	If impaired, please give details:
Pain	Yes ☐ No ☐ Location:_____	Pain scale 1-10_____
Potential Risks	Seizures* ☐ Wandering Risk ☐ DVT/Prophylaxis ☐ Supervision 1:1 ☐ Risk of Falls ☐ Falls Risk score: _____ *If yes for seizures, please complete appendix 1	

Infection Prevention & Control

Does the patient have a history of **any** Multidrug resistant organisms (including previous admissions)? E.g. MRSA, ESBL, VRE, CRE, Clostridium difficile. YES NO

If yes, please give details below of the type of organism, date, isolated & sample site.

MDRO DETAILS		
Name of organism	Date isolated	Sample site

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

Completion of Nursing Section:

Print Name: _____ **Signature: _____**

SECTION 3: TO BE COMPLETED BY THERAPIES

Pre-injury Information – To be completed by nominated member of therapies

Home Support/ADL Function	Previous Mobility
Communication & Swallowing	Cognition
Employment History & employment status at time of onset:	Alcohol/smoking/drug or substance abuse (history and current status:

Driver (please circle)	**Yes**	**No**	Details of any previous psychiatric history/mental health issues:
Driving Currently	**Yes**	**No**	
Type of Licence:			

Rehabilitation Complexity Scale Extended (RCS-E) To be completed by nominated member of therapies

	0	**1**	**2**	**3**	**4**
Care	Independent	1 carer	2 carers	3 or more carers	1:1
Risk	None	Low	Medium	High	Very High
Nursing	None	Qualified	Rehab Nurse	Specialist Nurse	High Dependency
Medical	Non active	Basic	Specialist	Potentially unstable	Acute medical/surgical

Therapy Disciplines	None	1	2-3	4-5	6 or more
Therapy Intensity	None	Low Level (less than daily)	Moderate e.g. daily	High (+assistant)	Very high (greater than 30 hours/week)
Equipment	None	Basic	Specialist	-	-
RCSE-E Total _____/22	C _____ N_____ M_____ Td_____ Ti_____ E_____				

Please indicate professions required to support identified needs:

Physiotherapy ☐ Speech & Language Therapy ☐ Occupational Therapy ☐ MSW ☐

Dietitian ☐ Psychology ☐ (currently no service available but tick if patient would benefit from input)

Other ☐ Give Details: _____

Estimated ability to tolerate intensive rehabilitatin	**Excellent**	**Good**	**Fair**	**Poor**
Willing to participate in therapy programme	**Yes**	**No**		
Ready to engage in therapy programme	**Yes**	**No**		

Any other issues that might impact on rehab:

Does this person have access to rehabilitation in another service?

If yes, please elaborate:

Section 3 (A) To be completed by Social Work (or delegate)

Social Information (please circle as applicable)

Family Support	Parent	Children	Spouse	Partner	Siblings	Other
Dependents	Yes	No	(could be children or other)			
Relationships	Single	Married	Partner	Separated	Divorced	Widow
Living Situation	Alone	Parent	Partner	Residential	Homeless	Other
House Type	Bungalow	Apartment	Multi-storey	Terraced	Other	Home Owner: **Yes** / **No**

Citizenship/Legal (please circle)			**Details**
Citizen	**Yes**	**No**	
Ward of Court	**Yes**	**No**	
Legal Case Pending	**Yes**	**No**	
TUSLA/Safeguarding concern	**Yes**	**No**	

Psychsocial(family support, relationship issues, sexual issues, social isolation, financial concerns, cultural factors, addiction etc)

Current status:

Main issues:

Goals**:**

Discharge Planning (home, home with support, supported living etc)

Completion of Social Work Section:

Print Name: _____ **Signature: _____**

Section 3 (B) To be completed by Physiotherapy (or delegate)

Mobility	**Transfers**	**Walking**	**Weight Bearing**	
	Independent ☐	Independent ☐	**Upper Limb**	
	Assist +1 ☐	Assist +1 ☐		
	Assist+2 ☐	Assist+2 ☐	**Lower Limb**	
	Hoist ☐	Unable ☐		

Physical (mobility, gait, transfers, coordination, balance, limb function, pain, spasticity etc):

Current status:

Main issues:

Goals**:**

Completion of Physiotherapy Section:

Print Name: _____ **Signature: _____**

Section 3 (B) To be completed by Occupational Therapy (or delegate)

Functional Status	**Washing and Dressing:**	**Seating**
	Independent ☐	Standard Chair ☐
	Assist +1 ☐	Special Seating ☐
	Assist+2 ☐	Unable ☐
	Details:	Details:

Home Environment	Bungalow ☐ Two Story ☐ Apartment ☐ Other: _____ Steps to access**:** _____ Stairs: Yes ☐ No ☐ Bedroom: Upstairs ☐ Downstairs ☐ Bathroom: Upstairs ☐ Downstairs ☐	**Other details:**

Functional Goals (personal care, ADL's, vocational etc):

Current status:

Main issues:

Goals**:**

Cognitive (sensory, information processing, memory, attention, executive functinoing, orientation, insight)

Current status:

Main issues:

Goals**:**

Completion of Occupational Therapy Section:

Print Name: _____ **Signature: _____**

Section 3 (C) To be completed by Dietetics (or delegate)

Therapeutic Diet: Yes ☐ No ☐ If yes, which therapeutic diet: _____ Diagnosis of Diabetes: Yes ☐ No ☐ Newly diagnosed: Yes ☐ No ☐ If yes, has patient been fully educated on appropriate dietary management of diabetes by dietitian in referring hospital: Yes ☐ No ☐ Prescibed ONS: Yes ☐ No ☐ If yes, please give details (product & dosage):	Current weight: _____kg Current height: _____m Malnutrition Risk: No Risk ☐ At Risk ☐ MUST Score if completed: _____ Assessed by Dietitian: Yes ☐ No ☐ Meeting Nutritional Requirements Orally *(as deemed by registered dietitian):* Yes ☐ No ☐ Unsure ☐	Stable on Dietitians Current Nutrition care plan and safe to transfer *(as deemed by registered dietitian):* Yes ☐ No ☐ If unsafe please provide further details on nutritional risk and issues:

Completion of Dietetic Section:

Print Name: _____ **Bleep / Phone contact: _____**

Section 3 (D) To be completed by Speech & Language Therapy (or delegate)	
Swallowing: Normal ☐ Impaired ☐	
Please circle Fluid Consistency: Level 0 Thin Fluids Level 1 Very mildly thick Level 2 Mildly Thick Level 3 Moderately Thick Level 4 Very Thick	Please Circle Food Consistency: Level 4 Puree Diet Level 5 Mince & Moist Level 6 Soft & Bite Sized Diet Level 7 Easy to Chew Level 7 Regular Diet *Please note, patients continuing to receive nutrition via enteral tube cannot be accepted
Swallowing Goals:	
Communication(speech, auditory comprehension, word finding, reading, writing, hearing etc): Current status: Main Problems: Goals**:**	
Completion of Speech & Language Section: **Print Name: _____** **Signature: _____**	

Referrer Details			
Referred by (Block Capitals)		**Date of Referral**	
Signature		**Position**	
Address & Contact No			

Please note this referral will only be accepted if all relevant sections are complete. Further information may be requested on receipt of the referral which may delay process

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Letter of Undertaking to Re-admit to Referring Hospital

Dr Wallace
Neuro-rehabilitation Service
Peamount Healthcare
Newcastle
Co Dublin

Date: _____

Attach addressograph label or complete the following

Client name: _____

DOB: _____ MRN: _____

Address: _____

_____

_____

Dear Dr Wallace _____,

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 NAME)** should it be required.

Yours sincerely,

Name_____Tel: _____ Bleep No: _____

Consultant ☐ SpR ☐ Reg ☐ SHO ☐ Intern ☐ *(tick as appropriate)*

Appendix1

Detail	Comments
Pre-injury/post injury onset	
Date of last seizure	
Type of seizure	
Seizure frequency	
Pattern	
Duration	
Warning Signs	
Trigger	
Recovery Period	
Buccal Midazolam*	

*Please attach personal plan for those who require/are prescribed emergency medications such as BM