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

Attach Client addressogragh label or complete:

Name: ____

DOB: _______________ MRN: __________________

Address: _____________________________________

____

____

PEAMOUNT HEALTHCARE AGE RELATED REHABILITATION SERVICE APPLICATION FORM

Applications will only be considered if mandatory sections are completed in full.

Checklist
MANDATORY **Sections A□ B □ C □ D □ E □** **Please attach Medical Details:** • **Copy of Kardex □ Insulin chart □** • **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 □ G □ H □ I □ J □ 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 or transitional care □

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

Any queries relating to referrals or admissions please contact:

Rachael Adderley Patient Flow 01 654 5943 / 087 904 0984

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 result and date:__________________________________

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 patient's 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 Ruth McDonagh
Age Related Rehabilitation
Peamount Healthcare
Newcastle
Co Dublin

Date: _________________

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

Dear Dr McDonagh,

I, ____ **(BLOCK CAPITALS)**, wish to confirm that I have

spoken with Dr / Mr / Ms / 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)*

Section E: Infection Control

Name:	MRN:	DOB:

Does the patient have a history of <u>any</u> Multidrug Resistant Organisms (Including previous admissions)? *e.g., MRSA, ESBL, VRECPE, Clostridioides Difficile, Amp C*	Yes □ No □ If the answer to this question is YES give details below.	
Name of organism	Date Isolated	Sample Site
If patient has a history of MRSA, please give details of any r MRSA decolonisation protocols prescribed during this admission	Date:	

COVID-19 SCREENING

NON COVID □ Has not tested positive for COVID 19 in past 90 days	OR	POST COVID □ Must be at least 10 days since date of positive test
Negative test required <72 hours prior to transfer Date:		Date of confirmed positive result:
Primary Vaccine Yes □ No □ Date of completion of primary vaccine: (Only relevant if booster vaccine not received)		Booster vaccine 1: Yes □ No □ Date Booster vaccine 2 Yes □ No □ Date
From outbreak ward Yes □ No □ Close contact Yes □ No □		NIV or AGP required Yes □ No □

CPE SCREENING REQUIREMENTS

Has the patient ever tested positive for CPE? YES □ NO □	If YES give details of date of positive result and sample site:
CPE contact? YES □ NO □	If YES give details of date of exposure and any CPE screens results since exposure:

PATIENT PLACEMENT

What type of IP&C precautions are currently in place:	Standard □ Transmission based (if YES what type?) Contact □ Droplet □ Airborne □
Where is the patient accommodated at present?	Single Room □ Multi-bedded Room □
Does the patient require NIV/AIRVO/AGPs?	Yes □ No □

REFERRER DETAILS

Name	Title	Contact:

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 ☐

NOTE: *A full enteral tube feeding referral form must be completed for any patients with enteral tube in situ*

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

Signature: ____ Tel: _________________________________

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 #____

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: ______________________________

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: ______________________________