Send completed referral form to: Rheumatology@peamount.ie
Please include relevant clinical letters, bloods and radiology reports with the referral to avoid unnecessary investigations on admission.

# Rheumatology Rehabilitation Referral Form

| | |
|---|---|
| *Exclusion Criteria:*<br>• *Psychiatric conditions or substance abuse issues which would impede participation in a therapy programme.*<br>• *Significant behavioural issues* | • *Requires respiratory support (e.g., tracheostomy/O2 saturation monitoring required/assisted ventilation)*<br>*Please link with service directly if:*<br>• *No discharge destination or significant barriers to discharge planning (see MSW section below).*<br>• *Those requiring >2 to handle (including for therapy input)* |

## Personal Details

| | | | | | | |
|---|---|---|---|---|---|---|
| Name:<br>Address:<br><br>**MRN:**<br>**Date of Birth:**<br><br>**Phone Number:**<br><br>**Email address:**<br>Family Contact/NOK:<br>Phone No: | Date of Referral: | | | | | |
| | Rheum Consultant and Rheum clinic attended: | | | | | |
| | GP:<br><br>Address:<br><br><br>Phone No: | | | | | |
| Is an interpreter required? Y ☐ N ☐<br><br>Language preference: | **Please ask!** | | | | Y | N |
| | Private insurance and provider: | | | | | |
| | LTI | | | | | |
| | Medical Card | | | | | |
| | Applied | Y | N | Approved | Y | N |

## Medical Information

Primary Diagnosis:

Date of diagnosis: Duration of symptoms:

| | |
|---|---|
| Medications: (highlight recent changes) | **Past Medical History:**<br>**(Recent cardiac history/ contraindications to exercise):** |
| Mobility Status:<br><br>Work status: | |

**Please include relevant clinical letters, blood, and radiology reports with the referral to avoid unnecessary investigations on admission.**

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| **Rehabilitation input required.** | | |
|---|---|---|
| **Discipline** | **Please indicate particular area of difficulty** | **Detail of therapist currently attending** |
| **Physiotherapy** | | |
| **Occupational therapy** | | |
| **Nursing** | | |
| **Medical social work** | | |
| **Psychology** | | |
| **Speech and language therapy** | | |
| **Dietetics** | | |
| **Pharmacy** | | |

**Please indicate goals of rehab as discussed with the patient:**

| **Please indicate the patient preference re: rehabilitation setting:** | **Please tick the relevant Outpatient programs:** |
|---|---|
| **Inpatient ☐ *or* Outpatient ☐** | **Inflammatory back pain ☐**<br>**Inflammatory arthritis ☐**<br>**Osteoarthritis ☐**<br>**Fibromyalgia/Persistent pain ☐** |

| **Social Information (please circle as applicable)** | | | | | | |
|---|---|---|---|---|---|---|
| **Family Support** | Parent | Children | Spouse | Partner | Siblings | Other |
| **Community Supports** | Home Care Package | | Home Help | Public Health Nurse | | Primary Care |
| **Living Situation** | Alone | Parent | Partner | Residential | *Homeless* | Other |

| INFECTION CONTROL INFORMATION (if available) | | |
|---|---|---|
| Does the patient have a history of <u>any</u> Multidrug Resistant Organisms (Including previous admissions)?<br>*e.g., MRSA, ESBL, VRE, CPE, Clostridioides Difficile, AmpC* | | Yes □ No □<br>If the answer to this question is YES give details below. |
| Name of organism | Date Isolated | Sample Site |
| | | |
| | | |
| | | |

| | |
|---|---|
| Referrer (PRINT NAME): | Signature |
| Job title | Hospital: |
| Date: | Contact number/email: |

***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.***

*For office use only:*

| | |
|---|---|
| *Referral received: Date_____* | *Referral entered on PAS: Y □ N □* |
| *Referral on hold: Y □ N □ Reason if Y _____* | *Source of referral contacted: Y □ N □* |