**Referral for Rehabilitation on Ward 26**

Patient information sticker

**Referrer Name……………………………………………………………**

**Referring Ward…………………………………………………………..**

**Referring Consultant………………………………………………….**

**Date……………………………………………………………………………**

**Medical Background**

Currently medically stable? Yes / No

Current tracheostomy? Yes / No If so; predicted date of decannulation ……………………………….

History of presenting condition

Past Medical History

Social History/Previous Functional Level

Goals for Rehabilitation:

**Nursing Background**

NEWS 2 score of 0 for past 24 hours? Yes / No

Dietetic input required? Yes / No

Currently under DOLs? Yes / No / Awaiting assessment

Currently requiring behaviour management? Yes / No

Please specify:

Currently requiring 1:1 nursing? Yes / No Specify level: 1 / 2 / 3

Active infection? Yes / No Please specify: ………………………………………………………………………………

Assistance required for self care? Independent / Assistance of 1 / Dependent

Current emotional status (e.g. is the patient low in mood, tearful, labile, anxious)

Details:

Any additional information: *e.g. mental capacity issues, mental health or forensic history, risk issues, family support needs*

Details:

**Physical Needs**

**Physical Needs**

**Physical Needs**

Assessed by Physiotherapy? Yes / No

Requires further Physiotherapy assessment and intervention Yes / No

Details

**Cognitive and Functional Needs**

Assessed by Occupational Therapy? Yes / No Assessed by Neuropsychology Yes / No

Cognitive assessment scores …………………………………………………………………………………………………………..

Requires further Occupational Therapy assessment and intervention? Yes / No

Details

**Speech and Language Needs**

**Speech and Language Therapy Needs**

Assessed by SALT? Yes / No

Requires further Speech and Language Therapy assessment and intervention Yes / No

Details

**Goals** 1.

2.

Has rehab been discussed with the patient and do they consent to this referral? Yes / No

If no, Is this referral being made in the patient’s best interests: Yes / No

**To be completed by Ward 26 in MDT (2pm each Thursday)**

**Patient Categorisation:** PatientCategory…………………… Service Level …………..……….

**Accepted Yes / No Date ………………………………..**

**Plan ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**

Referral to Walkergate Park? Yes / No Date referred: …………………………………