Holy Cross Hospital

Haslemere, Surrey, GU27 1NQ
Tel: 01428 643311
www.holycross.org.uk

PLEASE NOTE: THIS FORM IS FOR INPATIENT REFERRALS ONLY

INPATIENT REFERRAL FORM

Referrer's details

Name:	**Contact phone number:**
Job title:	**Organisation:**
Email:	

Patient's details

Patient name:	**DOB:**
Current address:	
Date of referral:	**NHS number:**
Diagnosis:	

Medical condition(s) *(please tick as appropriate)*

- ☐ Acquired Brain Injury (either Hypoxia or Traumatic Brain Injury)
- ☐ Spinal cord Injury
- ☐ Peripheral neuromuscular disease e.g. Guillain Barré syndrome, critical illness neuropathy
- ☐ Patients requiring complex respiratory care, eg tracheostomy and ventilator
- ☐ Patients requiring complex spasticity management including botulinum toxin
- ☐ Patients with neurodegenerative disorders (eg multiple sclerosis, Parkinson's Disease etc.) requiring specialist rehabilitation
- ☐ Stroke
- ☐ Motor Neurone Disease
- ☐ Post neurosurgery and major joint orthopaedic rehabilitation
- ☐ Functional neurological disorders
- ☐ Patients with prolonged disorders of consciousness (PDOC)
- ☐ Learning disability/Autism
- ☐ Dementia
- ☐ Challenging behaviour
- ☐ Transitional care for 18 years older
- ☐ Respite care
- ☐ Other:

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Additional information:

Previous medical history:

Respiratory: *(please tick as appropriate)*

☐ Tracheostomy If ticked, please state type/size:

☐ Cuffed ☐ Uncuffed

☐ Oxygen If ticked, please give details:

☐ Ventilator If ticked, please give details:

☐ Cough assist If ticked, please give details:

☐ Humidifier

☐ Speaking valve

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Nutrition: *(please tick as appropriate)*

Weight Height (if known)

☐ Oral diet ☐ Modified consistency If ticked, please give details:

☐ Assistance with feeding If ticked, please give details:

☐ Enteral feeding If ticked, please state type/size:

Enteral feed

Type

Amount in 24 hours

Rate per hour

Water *(volume in 24 hours)*

Other relevant details:

Elimination: *(please tick as appropriate)*

☐ Independent
☐ Needs assistance to toilet/commode
☐ Incontinent of urine
☐ Incontinent of faeces
☐ Urethral catheter If ticked, please state type/size:
☐ Suprapubic catheter If ticked, please state type/size:

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Tissue viability: *(please tick as appropriate)*

☐ Waterlow score

☐ Skin intact

☐ Pressure ulcer If ticked, please state grade:

Treatment:

☐ Tissue viability nurse involved If ticked, please give details:

Other relevant details:

Cognition and communication: *(please tick as appropriate)*

☐ Fully aware, able to understand and communicate without assistance

☐ Difficulty understanding and processing information

☐ Memory problems

☐ Low awareness state

☐ Needs communication aid If ticked, please describe:

Other relevant details:

Does the patient have capacity to consent for admission?

☐ Yes

☐ No

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Behaviour: *(please tick as appropriate)*

- ☐ No problems with behaviour
- ☐ Irritable at times
- ☐ Impulsive
- ☐ Verbally aggressive
- ☐ Physically aggressive
- ☐ Disinhibited
- ☐ Lacks insight

Other relevant details:

Mobility and posture management: *(please tick as appropriate)*

- ☐ Able to move or turn in bed independently
- ☐ Able to move or turn in bed with assistance
- ☐ Unable to move or turn in bed
- ☐ Able to walk independently
- ☐ Able to walk with assistance
- ☐ Wheelchair bound
- ☐ Has own wheelchair/seating system
- ☐ Has a wheelchair/seating system on loan
- ☐ Has been referred to local wheelchair/special seating services
- ☐ Yet to be referred to wheelchair/special seating services
- ☐ Patient using pressure relieving/air mattress
- ☐ Patient using a special sleep system

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Transfers: *(please tick as appropriate)*

☐ Able to transfer independently
☐ Able to transfer with assistance (banana board/ staff assistance)
☐ Transferred using a hoist and sling

Other relevant details:

Therapy interventions (PT/OT/SLT): *(please tick as appropriate)*

☐ Patient receives therapy daily
☐ Patient receives therapy once/ twice weekly
☐ Patient receives therapy as required
☐ Patient does not receive any therapy

Other relevant details:
(splinting, respiratory physio, Environmental Control System, hydrotherapy etc)

Tone management: *(please tick as appropriate)*

☐ Has increased muscle tone managed with oral medications
☐ Has increased muscle tone managed with Botox injections/oral medications
☐ Has increased muscle tone managed and awaiting appointment from specialists

Other relevant details:
(Phenol, IT Baclofen, contractures/ deformities)

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Next of kin details

Name:

Contact phone number:

Email:

Address:

Additional information

Please email the completed inpatient referral form to:
gina.guo2@nhs.net and **joanne.cooling1@nhs.net**