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| Text  Description automatically generated with medium confidence | QEF Care and Rehabilitation Centre  Woodlands Road  Leatherhead  Surrey KT22 OBN  Tel: 01372 841111  Email:  [hanin.shafie1@nhs.net](mailto:hanin.shafie1@nhs.net)  [michelle.stickings1@nhs.net](mailto:michelle.stickings1@nhs.net)  [kelly.cashel1@nhs.net](mailto:kelly.cashel1@nhs.net) |

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| **QEF REFERRAL FORM** | |
| Client name: | [Title] |
| Date of birth: |  |
| NHS no: |  |
| Address: |  |
| Home tel no: |  |
| Mobile no: |  |
| Email: |  |
| Present address if different from above or  Hospital and ward |  |
| GP Surgery/Doctor: |  |
| Nationality: |  |
| Ethnic origin: |  |
| Prior to injury, able to communicate in English? |  |
| Is an interpreter required? |  |
| Family/friends network and current housing:  Previous employment/ hobbies: |  |
| Next of kin name / relation: |  |
| NOK Contact number: |  |
| **MEDICAL AND NURSING** | |
| **Diagnosis, acute presentation** | Details: |
| Date of onset |  |
| **Past medical history:** |  |
| History of diabetes? | Yes/No  Details: |
| Shunt in situ? | Yes/No |
| History of seizures? | Yes/No  Details: |
| **Investigation, consultations pending** | |
| Radiology | Details: |
| Laboratory | Details: |
| Referrals | Details: |
| **Current Medications** | Details: |
| **Specialist Nursing skills required** | |
| Syringe drivers? | Yes/No |
| Venepuncture? | Yes/No |
| IV? | Yes/No |
| Tracheostomy care? | Yes/No |
| Nasogastric insertion and/or suction? | Yes/No |
| Other? |  |
| **Allergies/sensitivities** | |
| Drug? |  |
| Food? |  |
| Airborne? |  |
| **Hearing** | |
| Hearing aid? | Yes/No |
| **Vision** | |
| Glasses or contact lenses worn? | Yes/No |
| Visual field deficits? | Yes/No |
| **Fatigue**  Able to participate in therapy sessions?  Rest periods required? | Yes/No  Details:  Yes/No  Details: |
| **Current skin integrity** | |
| Any pressure areas or skin breakdown (location)? | Yes/No  Details: |
| Pressure-relieving equipment (e.g. airflow mattress or custom seating)? | Yes/No  Details: |
| Able to sit out? For how long every day? | Yes/No  Details: |
| **Sleep patterns /assistance required at night?** | Details: |
| Bed rails required? | Yes/No |
| Standard or specialised bed required e.g. bed length/width/bariatric |  |
| **Is 1:1 required?** | |
| Why?  How much? | Yes/No  *(NB. we are not an open ward with line-of-sight monitoring)* |
| What 1:1 support are they currently receiving? |  |
| **MOBILITY** | |
| History of falls? | Yes/No  If yes details: |
| **Transfers – assistance or equipment required?** | |
| Lying to sitting? |  |
| Sit to stand? |  |
| Rolling? |  |
| Toileting? |  |
| Bath/shower? |  |
| Manual/powered wheelchair required? | Yes/No If yes – model/type: |
| If none, has a referral been made? To which supplier/ funder? |  |
| Name/type of wheelchair cushion prescribed: |  |
| **SELF CARE – CURRENT FUNCTIONING** | |
| **Washing and dressing** | |
| Support needed? | Yes/No Number of carers required? |
| Strip wash? | Yes/No |
| Shower? | Yes/No |
| Dressing? | Yes/No |
| Time required? |  |
| Continent of bladder/bowels? | Yes/No |
| Catheter in situ? | Yes/No |
| If not, how is continence managed? |  |
| **SWALLOWING AND COMMUNICATION** | |
| Swallowing problem? | Yes/No |
| Has swallowing been assessed? | Yes/No |
| Current recommendations for fluids and food, including strategies (e.g. needs food cut up) |  |
| **Communication** | Details: |
| Expression  (able to convey message) |  |
| Level of understanding |  |
| Speech difficulties, voice changes |  |
| AAC (communication aids) used |  |
| **COGNITION AND PERCEPTION** | |
| Evidence of acute amnesia/PTA | Yes/No |
| Difficulties with attention/concentration? | Yes/No |
| Orientated to time? | Yes/No |
| Orientated to person? | Yes/No |
| Orientated to place? | Yes/No |
| Any impulsivity observed? | Yes/No |
| Any memory difficulties? | Yes/No  Details of any cog assessments conducted: |
| **BEHAVIOUR & MOOD** | |
| **Current/history of depression?** | Yes/No  Details: |
| **Suicidal ideation or deliberate self-harm?** | Yes/No  Details: |
| **Any other mental health issues?** | Yes/No |
| **If so is there a current risk assessment?** | Yes/No  *(Please attach if so)* |
| **History of abusive behaviour?** | Yes/No  Details: |
| **Incidents of verbal/physical aggression to people/objects?** | Yes/No  Details:  *(Please attach any behaviour logs/ABCs)* |
| **History of absconding?** | Yes/No  Details: |
| **MENTAL CAPACITY** | |
| **Does client have capacity to consent to this referral/their discharge plan?** | Yes/No  *(Please add details of BI decision if ‘no’)* |
| **Currently under a DOLS?** | Yes/No |
| **Power of Attorney in place?** | Yes/No  Details: |
| **DISCHARGE DESTINATION** | |
| **Has final destination been identified?** | Yes/No  Details: |
| **Concerns/issues regarding final discharge destination or safeguarding?** | Yes/No  Details: |
| **Have social services been involved?** | Yes/No  Details: |
| **Has a case manager been appointed?** | Yes/No  Details: |
| **ADDITIONAL INFORMATION** | |
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| REFERRER’S DETAILS | |
| *Name:* | *Contact Tel No:*  *Profession:* |
| *Contact Address:* | *Email Address:* |
| *How did you hear of the Care and Rehabiliation Centre:* | |
| *Referrer’s signature:* | *Date:* |

**PLEASE RETURN FORM TO:**

