

The Royal Hospital Donnybrook

Morehampton Road, Donnybrook, Dublin 4, Ireland.
Tel: (01) 4066600

Place patient I.D.
Sticker here

Referral Form Short-term Post Acute Rehabilitative Care programme. (SPARC)

Dear Colleague,

The SPARC programme is suitable for older people who are medically stable, fit for discharge from acute care but who require a further period of short term, multidisciplinary in-patient care during the post-acute phase to optimise recovery and independence.

Admission criteria

Suitable for patients:

- Aged 65 years and over;
- Who are medically stable and fit for discharge from acute care;
- Who can transfer independently or with minimal assistance/assistance of 1;
- Who have completed a home assessment visit, where appropriate;
- Who are expected to be ready for discharge home in 2-6 weeks.

Exclusion criteria

Unsuitable for patients:

- Who have entered the palliative stage of any illness;
- Who have challenging/wandering/exit seeking behaviours;
- Whose needs cannot be met by the SPARC team at The Royal Hospital Donnybrook.

In order to ensure that there are no unnecessary delays in processing your patient's referral please ensure each section is completed by the treating healthcare professional prior to faxing this form. If you require further information please contact Noreen Frawley, CNM 2 on **01 4066678**.

Once completed, please fax the referral form to the SPARC team on Larches Unit at **(01) 4066744**.

Thank you.



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Patient's Details

Name: _____ Date of Birth: ___/___/___

Address: _____

Date of admission to hospital: _____

Please give the date on which the patient expected to be ready for discharge from acute care? ___/___/___

Has the patient been informed that this referral is being sent: Yes No

Referrer Details

Referring Hospital / Facility: _____ Referral Date ___/___/___

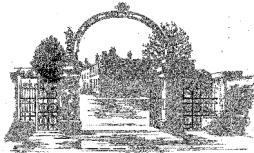
Ward / Area: _____

Contact Person: _____

Contact Phone No: _____ Fax No: _____

**This section is for the
RHD Team's use only.**

Please place referral
receipt stamp here and
include date ➡



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NURSING SUMMARY

Next of Kin/Representative: _____ Relationship to patient: _____

Address: _____

Telephone: _____

Has the above person been informed that referral is being sent? Yes No

Known allergies (specify): _____

Nutrition: Oral NGT PEG Diet: _____

Fluids: _____

Skin integrity/Wounds (specify location/grade etc): _____

Dressings/Treatments: _____

Does the patient have any communicable diseases or infection control issues? Yes No

If yes to above please comment: _____

Please complete Barthel in full below.

Barthel Index		SCORE
Mobility	Immobile (0) Wheelchair independent (1) Walks with help (2) Independent (3)	
Transfer	Unable (0) Major Help (1) Minor Help (2) Independent (3)	
Stairs	Unable (0) Needs Help (1) Independent up and down (2)	
Bowels	Incontinent (0) Occasional accident (1) Continent (2)	
Bladder	Incontinent (0) Occasional accident (1) Continent (2)	
Toilet use	Dependent (0) Needs some help (1) Independent (2)	
Bathing	Dependent (0) Independent (1)	
Grooming	Needs help (0) Independent (1)	
Dressing	Unable to help (0) Needs help (1) Independent (2)	
Feeding	Unable to feed themselves (0) Needs some help (1) Independent (2)	
Independent (20) Low Dependency (16-19) Medium Dependency (11-15) High Dependency (6-10) Maximum Dependency (0-5)		TOTAL

Cognitive status (any history of confusion, delirium): _____

Additional comments/Specific nursing issues: _____

Completed by: (PRINT) _____ Signature: _____

Contact Number: _____ Date: ____/____/____



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MEDICAL SUMMARY

Is this patient fit for discharge from acute care? Yes No

Does this patient require further in-patient rehabilitation? Yes No

Diagnosis: (include reason for current admission) _____

Past medical/surgical history: _____

Investigations: Relevant abnormal results (bloods, radiology, cardiology etc)

Current status:

Include current medical problems requiring active treatment. Please also clarify the patient's Resus. Status if this was addressed during admission.

MMSE score (or other cognitive
assessment): _____

O.P.D. appointments pending: (Please list)

Consultant: _____

Referring Medical Practitioner: _____

Contact Phone / Pager No.: _____ Date: _____



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REFERRAL REVIEW RECOMMENDATIONS

This section to be completed by The Royal Hospital Donnybrook.

Date referral received: ___/___/___

Date referral reviewed by team: ___/___/___

Referral Source _____

Diagnosis: _____

Patient meets Rehabilitation Admission Criteria: Yes No

Is a review/assessment of the patient in the acute hospital by the RHD CNM and/or Medical Director required? Yes No

If Yes to the above, please give date of planned assessment visit? ___/___/___

Team Recommendations (including notification of bed availability):

Signed: _____ Print: _____
On behalf of the team, RHD.

Date: _____

Referring Hospital / Facility notified of team recommendations: Yes No

Date: ___/___/___ By Phone Fax

By whom: _____