The Royal Hospital Donnybrook
Morehampton Road, Donnybrook, Dublin 4, Ireland.

Tel: (01) 406 6742 E-mail: admissions@rhd.ie Fax: 496 7571

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The Royal Hospital Donnybrook
Referral Form

Admissions Office
Ph: (01) 406 6742 E-mail: admissions@rhd.ie Fax: (01) 496 7571

- Each section must be completed by the treating health professional and goals for rehabilitation must be indicated.
- Once completed, please e-mail/fax the referral form to the RHD Admissions Office
- Only patients who meet the admission criteria will be accepted
- Please do not organise patient transfer until the Nurse Manager has confirmed that the patient has been accepted for rehabilitation, and has confirmed bed availability.
- If rehabilitation of the patient is no longer appropriate, the patient may, in certain circumstances, be returned to the referring hospital.
- Need more information? Please contact us on the number above.

REFERRAL DETAILS:

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

Ward/Area: _____

Contact Person: _____ E-mail Address:_____

Contact Phone No_____ Fax No: _____

Anticipated length of stay: _____

SPARC (Male & Female): Short-term Post Acute Rehabilitative Care	>65yrs	4–6 weeks duration
PARC (Female): Post Acute Rehabilitative Care	>65yrs	3-6 months duration
General Rehabilitation:	>65yrs	4-9 months duration
Stroke Rehabilitation:	<65yrs&>65yrs	4-9 months duration
Neuro-Rehabilitation	<65yrs	4–12 weeks duration

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PATIENT DETAILS

Referring Hospital MRN:_____

Forename:_____ **Preferred Name :**_____**Surname:**_____

Ph. No:_____ **Mobile Ph.**_____

Home Address:_____

Date of Birth:_____ **Age:**_____ **Sex:**_____

Marital Status:_____ **Religion:** _____

Next of Kin/Contact:_____**Relationship:** _____

Address: _____

Ph. No:_____ **Mobile Ph.** _____

Date of Admission to Referring Hospital:_____

GP:_____ **Address:** _____

Tel:_____ **Fax:** _____

Has the referral process been explained to the Patient: Yes ❑ No ❑ _____

Has patient/family consented to Rehab: Yes / No _____

Is the patient motivated to participate in Rehab Programme? Yes ❑ No ❑ _____

Is English the patient's first language: Yes ❑ No ❑ Please state first language: _____

Referring Consultant's Name: _____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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MEDICAL SUMMARY

Patient Name:_____ **Drug Payment Scheme: Yes ❑ No ❑**

Consultant:_____ **Date of Birth:** _____

Principle Diagnosis:

- _____
- _____
- _____
- _____

Past Medical/Surgical History/Previous Hospital:

_____

_____

Geriatrician Review: Yes ❑ No ❑ Name:_____ **Date:**_____

Psychiatric Review: Yes ❑ No ❑ Name:_____ **Date:**_____

Please enclose details of Geriatrician/Psychiatric report and follow up details Yes ❑ No ❑

***Please see "Psychology Assessment" page 14**

_____

Details of all relevant Investigations: (where appropriate)

- _____
- _____
- _____

Orthopaedic Cases: (please specify contraindications for further physio)

- _____
- _____

Current Medication Prescription Attached? Yes ❑ No ❑

Reason for Rehabilitation:_____

Timeframe Required:_____

OPD appointments:_____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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NURSING REPORT

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

Known Allergies: (specify) _____
_____
_____

State of consciousness:

Alert ❑
Lethargy/Fatigue ❑
Confusion/Dementia ❑

Intake (specify): Oral/NGT/PEG
MUST Score: _____
Diet: _____
Fluids: _____
Supplements: _____
Weight:_____
BMI: _____

Aids/prosthesis (specify): _____
_____

Does the patient have a history of wandering/exit seeking behaviour: _____
_____

Specific equipment needs:_____
Skin integrity/wounds(specify location/grade etc.)

Current MRSA Status:_____
Date: _____
_____
Sites Detected:_____

Swabs taken: Yes/No_____
Date:_____
Results: Detected/Not Detected_____
Waterlow:_____

Dressing/Treatment:_____

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

If Yes, please comment:_____

Communication:

Visual impairment Yes/No (specify):
_____

Hearing impairments Yes/No (specify):
_____

Speech impairment Yes/No (specify):
_____

Other sensory impairment Yes/No (specify):
Infection Yes/No (specify):
Oral Health: _____

Dressing/Treatments: _____
_____

Elimination:
Bladder: Continent/Incontinent/IDC/SPC
Bowels: Continent/Incontinent
_____
_____
_____

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Nursing continued…..

Please complete Barthel in Full (this is compulsory)

		SCORE
MOBILITY	**Immobile (0) Wheelchair Dependant (1) Walks with help (2) Independent (3)**	
TRANSFERS	**Unable (0) Major help (1) Minor Help (2) Independent (3)**	
STAIRS	**Unable (0) Needs Help (1) Independent up & down (2)**	
BOWELS	**Incontinent (0) Occasional accident (1) Continent (2)**	
BLADDER	**Incontinent (0) Occasional accident (1) Continent (2)**	
TOILET	**Dependent (0) Needs 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)**	

	TOTAL
Independent (20) Low Dependency (16-19) Medium Dependency (11-15) High Dependency (6-10) Maximum Dependency (0-5)	

Bed Transfers:_____ **Toilet Transfers:**_____

_____ _____

_____ _____

Does the patient have a history of falls: Yes ❑ No ❑ _____ _____

Hygiene needs (specify):_____

_____

Cognitive status (any history of confusion/agitation/wandering):_____

_____

Additional Comments/Specific Management Problems/Nursing Issues:

_____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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SOCIAL WORK REPORT

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

Next of Kin/Support Network:

_____

_____

Details of Home Situation:

Lives Alone: Yes ❑ No ❑ Lives with Other: _____

_____

Community Supports in Place Prior to Admission:

_____

_____

_____

Medical Card: Yes ❑ No ❑ Medical Card No. _____

Discharge supports applied for (specify):_____

PHN Yes ❑ No ❑ Name:_____ **Ph:**_____ **Referral sent: Yes ❑ No ❑**

Health Centre:_____

Private carers: Yes ❑ No ❑ _____

HCP applied: Yes ❑ No ❑ _____ **No. of Hours Requested:**_____

HCP Approved: Yes ❑ No ❑ _____**No. of Hours Granted:**_____

Area Care Co-Ordinator: _____ **Ph:** _____

Discharge Plan: _____

_____

_____

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Social Work continued….

Please document any family, housing, transport, financial, substance issues/challenging behaviour etc, the client may have, which could effect a positive outcome for the client:

_____

_____

_____

Estimated length of stay:

_____

Is patient aware of discharge plan: Yes ❑ No ❑

If no, reason why? _____

_____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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PHYSIOTHERAPY ASSESSMENT

Please include considerations such as Physiotherapy interventions and treatment goals to date, other factors impacting on treatment (including cognitive, emotional and motivational state), transfers (level of assistance required and equipment requirements including hoist type), mobility, gait, sitting balance and any other relevant comments.

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

Physiotherapy Treatment Commenced on: _____

Patient Discharged from Physiotherapy on:_____

Reason for Referral: _____

Main Physical Problems: **1.** _____

2. _____

3. _____

Functional Level: (ALL BOXES TO BE FILLED)

Functional Level	Pre-Admission Baseline	Current status in Referring Hospital	Potential status on discharge from Referring Hospital	If not assessed, state why
Bed Mobility				
Bed to Chair				
Mobility				
Mobility on Stairs				
Upper limb Function				

Requires further Physiotherapy: Yes ❑ **No** ❑ _____

Treatment to Date: _____

_____

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Physiotheraphy continued….

Rehab Goals: (please specify)

_____

_____

_____

_____

BERG Balance Scale: _____

MAS: _____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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OCCUPATIONAL THERAPY ASSESSMENT

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

Social History:_____

_____

Home Environment:_____

Previous Functional Baseline:_____

Seating/Pressure care/Waterlow Score: _____

_____

Current Mobility and ADL Status:_____

_____

MMSE: _____ **ACE Score:** _____ **Barthel Score:** _____

Cognition/Perception: _____

OT Goals for Rehabilitation: _____

Home/Access Visit completed: (date) _____ ***(please attach report)***

Equipment provided: _____

Referral to Community/PCCC OT: _____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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SPEECH AND LANGUAGE THERAPY (SLT) ASSESSMENT

Please complete even if this patient has been discharged from your SLT service.

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

General Information

Date SLT commenced: _____

Date SLT completed (if now discharged): _____

Frequency of input to date: _____

Full report attached ❑

Social History:

_____

Communication Function (language, higher level, speech, voice, cognitive-linguistic)

Pre-morbid communication status:

_____

Main areas of difficulty:

_____

Formal Assessments Completed (detail and dates)

_____

Changes to date:

_____

Current recommendations (strategies etc):

_____

Swallowing Function:

Pre-morbid swallow status:

_____

Main areas of difficulty:

_____

Changes to date:

_____

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SLT continued……

Current recommendations (diet and fluid consistencies, feeding techniques/strategies,etc.):

Instrumental Assessments Completed (details and dates):

Contact with Family/Carers:

SLT Goals for Rehabilitation:

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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DIETITIAN ASSESSMENT

Please include information on anthropometry, dietary requirements, nutrition interventions and any other information relevant to management.

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

Date Nutrition Intervention Commenced:_____

Main Nutritional Problems:

1._____

2._____

3._____

Height: _____ **Weight:** _____ **BMI:** _____

Usual Weight: _____

Recent weight change: _____

MUST Score: _____

Nutrition Care Plan: _____
_____

Prescribed supplements:

- _____
- _____
- _____

Community Services Required: Yes ❑ No ❑

Contact Name in Community: _____ **Ph. No:** _____

_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____

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PSYCHOLOGY ASSESSMENT

***(Please complete even if Psychology Assessment has not taken place)**

Patient Name:_____ **Date of Birth:**_____

Consultant:_____

Please state any concerns regarding patient's mental health, including low mood, anxiety or behaviour changes.

_____
_____
_____
_____

Was the patient seen by Psychology or Psychiatry during the patient's admission? Yes ❑ No ❑

Name:_____ **Date:**_____

Contact information: _____

Details of assessment or treatment provided:

_____
_____
_____
_____

Follow-up arrangements:_____

Report attached: Yes ❑ No ❑

Is there a previous history of mental health problems, including depression, anxiety, psychosis, substance abuse? Please give details.

_____
_____
_____
_____

Please list any previous Mental Health Services involvement (if known):

_____
_____
_____
_____

Professional's Details

Name (please print):_____ **Bleep/Phone No.**_____

Signed:_____ **Date:**_____

Professional Title:_____ **E-mail Address:**_____