

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

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 DE	TAILS:	
Referring Hospital/Facility:	Refer	ral Date//
Ward/Area:		
Contact Person:	E-ma	il Address:
Contact Phone No	Fax N	lo:
Anticipated length of stay: Short-Term Post Acute Rehabilitative Care (Larches and Willows Ward) General Rehabilitation (Male & Female): Stroke Rehabilitation (Male & Female): Neuro-Rehabilitation (Male & Female): >18	>65yrs >65yrs >18+	Up to 8 weeks duration Up to 12 weeks duration

The duration of rehabilitation will be determined by the patient's progress and

may be shorter or longer than the periods indicated above.

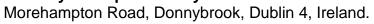
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PATIENT DETAILS

		Referring Hospita	II MRN:
Forename:	Preferred Name :		_Surname:
Ph. No:		Mobile Ph	
Home Address:			
Date of Birth:		Age:	Sex:
Marital Status:			Religion:
Next of Kin/Contact:		Re	elationship:
Address:			
Ph. No:		Mobile Ph	
Date of Admission to Refer	rring Hospital:		
GP:	Address:		
Tel <u>:</u>	Fax:		
Has the referral process be	een explained to the Patient:	Yes □ No □ _	
Has patient/family consent	ed to Rehab: Yes / No		
Is the patient motivated to	participate in Rehab Program	nme? Yes 🗆 No	o
Is English the patient's firs	t language: Yes □ No □	Please state first I	anguage:
Referring Consultant's Nar	me:		
Professional's Details			
Name (please print):		Bleep/Phone	e No
Signed:		Date:	
Professional Title:		E-mail Addr	ess:



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MEDICAL SUMMARY

Patient Name:	Drug Payment Scheme: Yes □ No □
Consultant:	Date of Birth:
•	
Past Medical/Surgical History/Previous Hospital:	
Geriatrician Review: Yes □ No □ Name:	
Psychiatric Review: Yes No No Name: Please enclose details of Geriatrician/Psychiatric re *Please see "Psychology Assessment" page 14	port and follow up details Yes 🔲 No 🖵
Current Medication Prescription Attached?	′es □ No □
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:		_
	cify)	
		Dist
		Fluids:
		Supplements:
State of consciousnes	s:	Weight:
		BMI:
Alert		
Lethargy/Fatigue		Aids/prosthesis (specify):
Confusion/Dementia		
seeking behaviour:	a history of wandering/exit	Specific equipment needs:
Current MRSA Status:		
Sites Detected:		Waterlow:
Dressing/Treatment:		
Does the patient have	communicable diseases or	infection control issues? Yes □ No □
If Yes, please commer	nt:	
Communication:		
Visual impairment Yes	/No (specify):	Dressing/Treatments:
Hearing impairments Y	es/No (specify):	Flinsingston
Speech impairment Ye	s/No (specify):	Elimination: Bladder: Continent/Incontinent/IDC/SPC Bowels: Continent/Incontinent
Other sensory impairm	nent Yes/No (specify):	
Infection Yes/No (spe		



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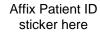
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Nursing continued.....

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)	
	Needs Some Help (1) independent (2)	
•	Low Dependency (16-19) Medium Dependency (11-15) y (6-10) Maximum Dependency (0-5)	TOTAL

Independent (20) Low Dependency (16- High Dependency (6-10) Maximum Depe		TOTAL
Bed Transfers:		
Does the patient have a history of falls:	Yes	
Cognitive status (any history of confusi	on/agitation/wandering):	
Additional Comments/Specific Manager		
Professional's Details		
Name (please print):	Bleep/Phone No	
Signed:	Date:	
Professional Title:	E-mail Address:	

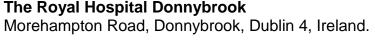




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SOCIAL WORK REPORT

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 Co			-
PHN Yes 🔲 No 🔲 Name:	Ph:	Referral sent: Yes 📮 🛚 I	No □
Health Centre:			
Private carers: Yes 🔲 No 🛚			
HCP applied: Yes □ No □	No. of Hou	rs Requested:	_
HCP Approved: Yes □ No □	No. of Hou	rs 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?		
<u>Professional's Details</u>		
Name (please print):	Bleep/Phone No	
Signed:	Date:	
Professional Title:	E-mail Address:	

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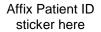


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PHYSIOTHERAPY ASSESSMENT

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 Na	Patient Name: Date of Birth:			
Consultar	nt:		-	
Physiothe	erapy Treatment C	ommenced on:		
Patient Di	scharged from Ph	ysiotherapy on:		
Reason fo	or Referral:			
Main Phys	sical Problems: 1	·		·
	2	2		
	3	3.		
	Fu	nctional Level: (A	ALL BOXES TO BE FILLED)	
Functional	Pre-Admission	Current status in	Potential status on discharge from	If not assessed,
Level	Baseline	Referring Hospital	Referring Hospital	state why
Bed Mobility				
Bed to Chair				
Mobility				
Mobility on				
Stairs				
Jpper limb				
Function				
-	-	.,		





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Physiotheraphy continued		
Rehab Goals: (please specify)		
BERG Balance Scale:		
MAS:		
<u>Professional's Details</u>		
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 S			
Current Mobility and ADL Status:_			
MMSE:			
Cognition/Perception:			
OT Goals for Rehabilitation:			
Home/Access Visit completed: (da	ite)		_ (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 o	consistencies, feeding techniques/strategies,etc.):
Instrumental Assessments Completed (de	etails and dates):
Contact with Family/Carers:	
SLT Goals for Rehabilitation:	
Professional's Details	
Name (please print):	•
Signed:	
Professional Title	F-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 Interve	ntion Commenced:		_
Main Nutritional Prob	lems:		
1			
2			
3			
Height:	Weight:	BMI:	
Usual Weight:			
Recent weight change:			
MUST Score:			
Nutrition Care Plan:			
Community Services Re	equired: Yes 🗆 No 🗅		
Contact Name in Comm	unity:	Ph. No:	
Professional's Details	<u>3</u>		
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 changes.	health, including low mood, anxiety or behaviour
Was the patient seen by Psychology or Psychiatry du	ring the patient's admission? Yes □ No □
Name: Da	te:
Contact information:	
Details of assessment or treatment provided:	
Follow-up arrangements:	
Report attached: Yes No	
Is there a previous history of mental health problems, abuse? Please give details.	, including depression, anxiety, psychosis, substance
Please list any previous Mental Health Services involv	vement (if known):
Professional's Details	
Name (please print):	Bleep/Phone No
Signed:	Date:
Professional Title:	E-mail Address: