

Referral for Admission

The information requested is essential to help us decide on the appropriateness of the referral and for us to consider which unit within the Blackheath Brain Injury Rehabilitation Centre will best meet their needs.

Your assistance in completing the form is appreciated since incomplete forms result in delay.

Please tick the box to indicate the type of service you consider may be appropriate for your patient.

- The Thames Brain Injury Rehabilitation Unit is registered with the Healthcare Commission and the Mental Health Act Commission and is therefore able to admit detained patients. Rehabilitation is provided in a safe environment for patients with cognitive and behavioural disability following acquired brain injury, e.g. traumatic, anoxic, younger strokes. Some patients also have a mental illness.
- The Heathside Neurodisability Unit is registered with the Commission for Social Care Inspection. The unit provides rehabilitation for individuals following brain injury or other neurological conditions, e.g. stroke, multiple sclerosis, Parkinson's disease. The unit also provides long term care for a small number of patients with total physical dependency needs. The patients may have severe levels of physical disability and/or cognitive disability but behavioural disturbance is less of a feature

In addition to the information requested in this form we will require a detailed medical report at assessment, outlining the clinical status of the patient. It would also be most helpful if you could let us have copies of any recent medical, therapy, and care plan reports that may be available.

We will acknowledge the referral on receipt and advise you of the next step.

Thank you for completing this referral form.

Please return the referral form to:

Centre Manager
Blackheath Brain Injury Rehabilitation Centre
80-82 Blackheath Hill
London SE10 8AB

Phone: 0208 692 4007

Fax: 0208 694 5444 or 0208 694 8316

Website: www.huntercombe.com

Referral Form

Please complete all sections in full. Failure to do so could result in a delay in assessment. If information is not available/relevant please indicate.

Referrer		G.P.	
Date:		Name:	
Name of referring unit:		Address:	
Position:			
Relationship to patient:			
Phone:			
Fax:			

Patient Details <i>(N.B. Do not use coloured labels if sending by fax)</i>			Office use only
Name:		M / F	Primary Care Trust
Address: (home)			
Phone:		Post code:	Date received:
DoB:		Marital status:	
Age:		Occupation:	
NHS no:			

The patient is currently:

- An inpatient on: _____ ward, at the _____ hospital
 Phone: _____ (ward/hospital & ext. number)
- At home at the above address
- Other *(please specify)* _____

Next of Kin: <i>are they aware of the referral?</i>		Y/N	Other contact information <i>(optional)</i>	
Name:			(e.g. relative/friend)	Phone:
Address:				
Phone:	Day:			
	Evening:			
Fax:				
Relationship to patient:				

Please advise the administration office if there is a requirement for the patient/service users' guide and future patient/relative/carer information to be provided in an alternative format or language.

Capacity to Consent to Treatment	Yes	No (state name of Independent Advocate / Family)

Clinical Information

Date & type of brain injury/neurological condition including duration of unconsciousness/PTA	<hr/> <hr/> <hr/> <hr/>
Other injuries sustained	<hr/> <hr/> <hr/> <hr/>

Medical Disorders:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Known Hepatitis |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> MRSA+ | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Known HIV+ | <input type="checkbox"/> Other |

Is the patient medically stable?	Details:
Yes/ No	<hr/> <hr/> <hr/> <hr/>

(Please delete as appropriate)

Is the patient being held under the Mental Health Act?	If yes, which section and what is the expiry date?
Yes/ No	<hr/> <hr/> <hr/> <hr/>

Current Functional Level

Cognitive Impairment	mild	moderate	severe
Communication Problems	mild	moderate	severe
Self-Care	independent	supervision/prompting	1 x Person (physical assistance) Full dependence

Does the patient have?	Yes	No	Comments
A Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
NG tube	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Urinary catheter	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Faecal incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Pressure sores	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

Mobility

Walks independently	Walks with assistance	Independent in a wheelchair	Attendant propelled	Bed Bound
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Transfers

Independent	With one person	With two people	hoisted
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Risks and Behaviours

Please send current risk assessment or give information regarding risk behaviours (e.g. falls, agitation, aggression, absconding, poor safety awareness, self harm/suicide, shouting) in terms of their frequency, severity, and include any detail on whether the behaviours are current or precede the brain injury, and whether there is any pre-meditation. This will assist us in making safe and informed decisions in terms of needs and in considering which unit is most suitable. Please indicate behavioural difficulties below:

Which therapies / services are currently involved?

- | | | |
|--|--|---|
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Homecare | <input type="checkbox"/> Discharge Co-ordinator |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Legal | <input type="checkbox"/> Case Manager |
| <input type="checkbox"/> Dietician | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Day-care | <input type="checkbox"/> Speech & Language Therapy | |

Funding

Please give the contact details of the named person in the Primary Care Trust, Local Authority, Legal Firm, or Insurance Company or individual accepting or requested to accept responsibility for funding this placement at the Blackheath Brain Injury Rehabilitation Centre.

Assessment Needs

Please select the following requirements for assessment: (delete as appropriate)

- | | |
|--|----------|
| Is the patient able to travel? | Yes / No |
| Is the patient able to be assessed at BBIRC? | Yes / No |
| Are you able to provide transport? | Yes / No |
| Does the patient require an interpreter? | Yes / No |
| Are there any medical risks involved for an assessment here? | Yes / No |

Please list any behavioural risks for an assessment here:

Please list known allergies (medical and food):

Please list food preferences if patient could be assessed here:

Thank you for completing this enquiry / referral form.