

CHD REHABILITATION



MAKE A REFERRAL

Referral for:	Rehabilitation <input type="checkbox"/>	Nursing Care <input type="checkbox"/>
Preferred location:	Bagshot Park <input type="checkbox"/>	Kingston <input type="checkbox"/>

Patient's Details:

Surname:	Title: Mr/Mrs/Ms/Miss
Forename(s):	Date of Birth:
Address:	Telephone No:
	Next of Kin:
Postcode:	Relationship:
NHS No:	Telephone No:

Medical History: MUST BE COMPLETED IN FULL (please additional sheet if required)

Diagnosis:	Scan/investigation results/previous surgery:
Date of onset:	
Past Medical History/Co-morbidities	Drug History:
Social History:	
Present Functional Status:	
Airway: Speech: Swallowing: Cognition: Behaviour: Feeding: oral diet <input type="checkbox"/> (<i>independent</i> <input type="checkbox"/> <i>requires assistance</i> <input type="checkbox"/>) NGT <input type="checkbox"/> PEG <input type="checkbox"/> TPN <input type="checkbox"/> Bladder/Bowel: incontinent <input type="checkbox"/> continent <input type="checkbox"/> catheter/convene <input type="checkbox"/> (please specify) _____ Skin: intact: yes <input type="checkbox"/> no <input type="checkbox"/> grade & location: _____ Waterlow score: _____ Mobility: (<i>include any aids used</i>)	

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Therapies/ Services Involved: Please tick and provide therapist name & contact telephone number

Physiotherapy	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Speech & Language Therapy	<input type="checkbox"/>
Psychology	<input type="checkbox"/>
Other	<input type="checkbox"/>
Have you referred onto any other service? Yes <input type="checkbox"/> No <input type="checkbox"/> Please state name & contact details below:	

Anticipated discharge destination: (N/A for long-term admissions)

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Funding: Private: CCG (Please specify which CCG including contact name & telephone number)

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Doctor's Details:

Registered GP:	Consultant Name:
Address:.....	Address:.....
.....
Postcode:.....	Postcode:.....
Telephone Number:.....	Telephone Number:.....

Referrer Details:

Name:	Profession:
Unit/Ward:	Hospital:
Address:	Telephone:
Postcode:	Date of referral:
Email:	Signature:

Referring consultant/clinician signature:

Date:

Please email to enquiries@chd-rehab.com

OR CALL: 07960 158 3031

