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.

Anticipated length of stay: _______________

SPARC (Male & Female): >65yrs 4–6 weeks duration
Short-term Post Acute Rehabilitative Care

PARC (Female): >65yrs 3-6 months duration
Post Acute Rehabilitative Care

General Rehabilitation: >65yrs 4-9 months duration

Stroke Rehabilitation: <65yrs & >65yrs 4-9 months duration

Neuro-Rehabilitation <65yrs 4–12 weeks duration
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:_________________________
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: ___________________________
NURSING REPORT

Patient Name: ___________________________ Date of Birth: ___________________________

Consultant: ____________________________

Known Allergies: (specify) ____________________________ Intake (specify): Oral/NGT/PEG

MUST Score: ____________________________ Diet: ____________________________

Fluids: ____________________________ Supplements: ____________________________

State of consciousness: ____________________________

Weight: ____________________________ BMI: ____________________________

Alert ❑
Lethargy/Fatigue ❑
Confusion/Dementia ❑

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: ____________________________ Swabs taken: Yes/No___________________________

Date: ____________________________ Date: ____________________________

Results: Detected/Not Detected ____________________________

Sites 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): ____________________________

Dressing/Treatments: ____________________________

Hearing impairments Yes/No (specify): ____________________________

Elimination: ____________________________

Speech impairment Yes/No (specify): ____________________________

Bladder: Continent/Incontinent/IDC/SPC ____________________________

Other sensory impairment Yes/No (specify): ____________________________

Bowels: Continent/Incontinent ____________________________

Infection Yes/No (specify): ____________________________

Oral Health: ____________________________
Nursing continued.....

Please complete Barthel in Full (this is compulsory)

| MOBILITY                          | TRANSFERS                     | STAIRS                        | BOWELS                         | BLADDER                        | TOILET                         | BATHING                       | GROOMING                      | DRESSING                      | FEEDING                        |
|----------------------------------|-------------------------------|-------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Immobile (0) Wheelchair Dependant (1) Walks with help (2) Independent (3) | Unable (0) Major help (1) Minor Help (2) Independent (3) | Unable (0) Needs Help (1) Independent up & down (2) | Incontinent (0) Occasional accident (1) Continent (2) | Incontinent (0) Occasional accident (1) Continent (2) | Dependent (0) Needs Help (1) Independent (2) | Dependent (0) Independent (1) | Needs help (0) Independent (1) | Unable to help (0) Needs help (1) Independent (2) | Unable to feed themselves (0) Needs some help (1) Independent (2) |

Score

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<th>MOBILITY</th>
<th>TRANSFERS</th>
<th>STAIRS</th>
<th>BOWELS</th>
<th>BLADDER</th>
<th>TOILET</th>
<th>BATHING</th>
<th>GROOMING</th>
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<td>Unable to help (0) Needs help (1) Independent (2)</td>
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<td>Unable to feed themselves (0) Needs some help (1) Independent (2)</td>
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</table>

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

TOTAL

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:_________________________
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: ___________________________

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
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:_________________________
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)

<table>
<thead>
<tr>
<th>Functional Level</th>
<th>Pre-Admission Baseline</th>
<th>Current status in Referring Hospital</th>
<th>Potential status on discharge from Referring Hospital</th>
<th>If not assessed, state why</th>
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</thead>
<tbody>
<tr>
<td>Bed Mobility</td>
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<td>Bed to Chair</td>
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<tr>
<td>Mobility</td>
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<td>Mobility on Stairs</td>
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<tr>
<td>Upper limb Function</td>
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Requires further Physiotherapy: Yes □ No □ _____________________________________________________

Treatment to Date: _________________________________________________________________
Physiotherapy 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:____________________________
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: ______________________
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:
____________________________________________________________________________________


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:____________________
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: __________________
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: ___________________________