NATIONAL REHABILITATION HOSPITAL

REFERRAL FORM FOR ADULT OUTPATIENT PROGRAMME

All referrals must be sent with detailed medical reports and a current list of medications. Incomplete referrals, without this information, will be returned to the referrer.

Please email / send this completed form to: **referrals@nrh.ie** or by post to the Central Referrals Office, NRH, Rochestown Avenue, Dun Laoghaire, Co Dublin A92 E2H2

Please specify the programme(s) and whether **in-patient** ☐ or **out-patient** ☐:

Brain injury (BIP)	**Stroke**	**Spinal cord system of care** (SCSC including CIN, peripheral neuropathy)	**POLAR**[1]

For **Outpatient** referrals - **BIP, Stroke, SCSC and POLAR** (**P**rosthetic, **O**rthotic and **L**imb **A**bsence **R**ehabilitation) please complete sections 1 – 5

1. Patient demographic and referrer details

Patient Name:	**DoB:**
Current Location: **1:1 supervision required?**	
Address: **Eircode:**	**Contact Number:**
Primary language:	**Interpreter required:** yes / no
Medical Card number and expiry date: *If none please give application details in section 8*	**Long term illness card number:** *If none please give application details in section 8*
Nominated contact person (NCP name):	**NCP contact number(s):**
Residency / visa status?	**Referring Consultant and Hospital:**
GP name:	
GP Address:	**Address and contact details:**
GP Contact Number:	

[1] *prosthetic, orthotic and limb absence rehabilitation*

2. Medical details

Primary diagnosis / acute illness or injury / amputation (*must include date of onset)

Other / background diagnoses:

***** *if ESRD, attach details of dialysis provider(s) and schedules*****

Known allergies? Yes/No **Please give details**

DVT Prophylaxis? Yes/No **Please include in medications list**

History of primary diagnosis / recent injury or illness including all operative and non-surgical interventions and current medications
(attach medication list and all relevant reports including imaging, laboratory and operative reports):

Post-traumatic amnesia if TBI:

Please list HSCP and nursing interventions to date *(attach all available reports)*

If discharged from hospital, please list all community services involved:

3. Social and pre-injury information:	
Home supports:	**Mobility pre-injury**:
Employment:	**Driver:** yes/no **Driving Currently:** yes/no **Type of Licence:**

Social information						
Family Support	☐ Parent	☐ Children	☐ Spouse	☐ Partner	☐ Siblings	☐ Other
Living Situation	☐ Alone	☐ Parent(s)	☐ Partner	☐ Residential	☐Homeless	☐ Other
House Type	☐ Bungalow	☐ Apartment	☐ 2 storey	☐ Terraced	☐ Other	
Home Owner	□ Yes □ No					

4. Patient and family goals

5. Potential Risks
☐ Seizures* ☐ Risk of falls ☐ Forensic History **if yes for seizures, please complete appendix 2, p4*
Infection Status: ☐ C-Diff ☐ VRE ☐ MRSA ☐ Hep B ☐ Hep C ☐ HIV ☐ Other? *Please specify*

For out-patient referrals:

Doctor's signature:	
IMC number:	
Date:	
Phone number of contact Dr / nurse / HSCP	

Appendices

Appendix 1 - RCSE

Rehabilitation Complexity Scale Extended (RCS-E)

Complexity: Rehabilitation Complexity Scale Extended (RCS-E)

	0	1	2	3	4
Care	Independent	1 carer	2 carers	≥ 3 carers	1:1
Risk	None	Low	Medium	High	Very high
Nursing	None	Qualified	Rehab nurse	Specialist nursing	High dependency
Medical	Non active	Basic	Specialist	Potentially unstable	Acute medical/surgical
Therapy disciplines	None	1	2-3	4-5	≥ 6
Therapy intensity	None	Low level (< daily)	Moderate (eg daily)	High (+ assistant)	Very high (>30 hours/week)
Equipment	None	Basic	Specialist	-	-

RSCE: C_____ N_____ M_____ Td_____ Ti_____ E_____ Total_____/22

Appendix 2 – additional information for those with a history of seizures

Detail	*Comments*
Pre-injury/post injury onset	
Date of last seizure	
Type of seizure	
Seizure frequency	
Pattern	
Duration	
Warning signs	
Triggers	
Recovery period	
Buccal Midazolam (BM)*	

*Please attach personal plan for those who require/are prescribed emergency medications such as BM