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| \\Mwhb-fs-hq\CRT\Care Pathway Documents\New Logo\HSE Mid West Logo-01.jpg**Mid-West Community Neuro Rehabilitation Team Referral Form** |
| *Please complete this form by ticking the appropriate boxes or by writing your response in space provided. Incomplete information may unnecessarily result in a lower priority rating and a longer waiting time for the person referred.Please note: The CNRT Psychology Service does not offer an emergency mental health service - In case of an emergency please contact your GP, local out-of-hours GP, or attend your local Emergency Department.*  |
| **Personal Details** |
| Name |  | Address |  |
| Title |  | Date of Birth | D | D | M | M | Y | Y | Sex | **M** | **F** |
| Home phone No |  | Mobile No |  |
| Emergency contactName  |  | Emergency contact number |  |
| Email Address |  |
| Long Term Illness/ Medical Card No |  |
| GP (name & address) |  |
| Consultant (name & address) |  |
| National Physical & Sensory Disability Database Registered | **Y** | **N** |
| Is a translator required?  | **Y** | **N** | **Is transport available to attend the service****(Minimum of twice a week to maximum of 4 times)** | **Y** | **N** |
| **Diagnosis and cause of injury (Please include scan results if applicable)** |
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|  **Date of onset/ length of time since onset:** |
|  **Date of discharge from acute/rehab services or Primary care services:** |
| **Previous medical / surgical history** *(e.g. osteoporosis, asthma, heart problems, etc.)* |
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| **General health and emotional well-being** |
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| **Social history** *(Living arrangements? Family/ Previous and current work/ study status, leisure activities etc.* |
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| **Previous therapy input and outcome *(Attach reports if available)*** |
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| **Other services involved** *(Primary Care Team members, home help, personal assistant, meals on wheels etc.)* |
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| What therapies are you referring for: (please tick services required)  | Physiotherapy |  | Occupational Therapy |  |
| Speech and Language Therapy |  | Clinical Psychology |  |
| **Person’s abilities** |
|  Physical Ability (e.g. balance, strength, upper and lower limb function, transfers, mobility) |
| Communication (e.g. speaking, understanding, reading, writing) |
| Swallowing |
| Cognition (e.g. memory, thinking, planning, organising) |
| **Levels of independence and safety in daily activities** (Washing, dressing, household activities. Work, driving, falls etc.) |
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| **Any equipment used** (Hoist, wheelchair, walking stick, communication aid etc.) |
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| **Goals for therapy/ What the person would like to achieve with the team** |
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|  **Referrer Details** |
| Referred By (Block Capitals) |  | Date of Referral |  |
| Signature |  | Contact No |  |
| Address |  |
|  Relationship to client |
| Is the person referred aware of the referral?  | Y | N |

**Please note this referral will only be accepted if all relevant sections are complete. Please include reports where relevant and available. Further information/reports may be requested on receipt of the referral which may delay processing.**