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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 contact  Name |  | | | | | 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)** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **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.)* | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **General health and emotional well-being** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Social history** *(Living arrangements? Family/ Previous and current work/ study status, leisure activities etc.* | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Previous therapy input and outcome *(Attach reports if available)*** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Other services involved** *(Primary Care Team members, home help, personal assistant, meals on wheels etc.)* | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| 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.) | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Any equipment used** (Hoist, wheelchair, walking stick, communication aid etc.) | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Goals for therapy/ What the person would like to achieve with the team** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **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.**