Brampton
Care & Rehabilitation Centre

Referral Form

Required

PERSONAL DETAILS			
Name		***MRN***	
Likes to be known as		**Religion**	
PPSN		***Social Worker contact details***	
DOB		***Referring Facility name and address***	
Home Address		***Referring Consultant***	
Contact Number		***GP Name & Address***	
NOK name (relationship)		***GP Contact Number***	
NOK address and contact number		***Consent: Patient***	Yes/No
Ethnicity/First language		***Consent: Family/NOK***	Yes/No
Level of family input/any identified family difficulties			
Is an interpreter required		***Medical card: eligible/applied/approved***	
COVID-19 Vaccination Status		**FLU Vaccine status**	
MEDICAL DETAILS			
Current diagnosis & details of admission			
Relevant Investigations and/or Surgical Interventions			

Medications	*Allergies* Yes/No (Incl food)	*Kardex* Included Y/N *Able to self-administer medications?* Y/N
Past Medical History		
Completed by Print name	Job title	Contact number

Pre-morbid Function	
Mobility	Indoors Outdoors
Stairs	
Transfers	
PADLs	
DADLs	
Support	Informal Formal (HCP)
Cognition	
Vision	
Hearing	
Speech	
Falls History	
Social History	
Lives	Alone with spouse/partner With family Other:
Home Environment	Bungalow 2 storey house Apartment Other: Stairs/Steps: Bedroom: upstairs/Downstairs Bathroom: upstairs/downstairs Both
Occupation	
Leisure Activities	
Driving	

Brampton
Care & Rehabilitation Centre

NURSING REPORT

Weight/diet/intolerances to food

Weight increasing / decreasing		
Have you had any recent weight loss?		
Weight on admission		
Calculate	MUST	BMI
Height		

Continence

URINARY / BOWEL	
Continent (yes/no)	
Any condition effecting continence	
Incontinent (yes/no)	
Incontinence wear used currently	
Catheterized (yes/no)	
Stoma (yes/no)	
IF URINARY / SUPRA PUBIC CATHETER PRESENT	
Catheter type	
Catheter size	
Catheter site	
Date inserted	
Date change next due	
Reason for insertion	

Skin Integrity

Skin intact	
Pressure areas intact	
Feet intact	
Waterlow assessment & score	
Current wounds or stomas and dressing regimen	

Social history

Drug/Alcohol use Y/N	Details of inpatient/outpatient rehabilitation or supports
Place of birth	
Relevant history (education/schools/college attended etc) **Any literacy issues**	
Mood (pre-morbid)	
Mood (current)	
Neuro-psychiatry consultant name and contact details	
Seizures Y/N **Current management plan** **Neurologist name and contact details**	
Mental Health History (including inpatient admissions to mental health unit) **Name and contact details of psychiatrist/neuro-psychiatrist**	

PHYSIOTHERAPY REPORT

Print Name: **Contact details**

Current Function	**<u>Transfers</u>** Bed mobility: Lying to sitting: Sitting balance: Sit to stand: Bed to chair:	**<u>Mobility</u>** Indoor: Outdoor: **<u>Stairs:</u>** 1 rail ☐ 2 rails ☐ Left or right-handed dominance?
	<u>Upper Limb Function</u>	**<u>Upper Limb Outcome Measures</u>** Grip Strength 9HPT Fugyl Meyer Chedoke
	Problem List:	
	Outcome Measures: **Balance:**	
	Goals:	
	Other details:	

Print name: **Contact details**

OCCUPATIONAL THERAPY REPORT

Name: _____ **Date** _____

<table>
<tr>
<td rowspan="2">Current Function</td>
<td><u>Grooming:</u>
Independent ☐
Assist of 1 ☐
Assist of 2 ☐

Washing/Showering:

Independent ☐
Assist of 1 ☐
Assist of 2 ☐

Equipment used:

_____

_____

Dressing:

Independent ☐
Assist of 1 ☐
Assist of 2 ☐

Other Details:</td>
<td>Seating:
Standard Chair ☐
Standard Wheelchair ☐

Specialist Seating:
Tilt in space wheelchair ☐
Tilt in space comfort chair ☐
Unable ☐

Wheelchair Ownership
Yes ☐ No ☐

Pressure Care:

Waterlow Score _____

Pressure Cushion Provided
Yes ☐ No ☐
Details:

_____

Details:</td>
</tr>
<tr>
<td>Domestic Activities of Daily Living

Meal Preparation
Assistance of 1 ☐
Unable ☐

Details:</td>
<td>Phone/Computer Use

Assistance of 1 ☐
Unable ☐

Details:</td>
</tr>
</table>

Cognition: Deficits

Please tick all that apply:

Memory ☐ Attention ☐ Information Processing ☐ Planning ☐

Problem Solving ☐ Executive Functioning ☐ Orientation ☐ Insight ☐

Impulsivity ☐ Praxis ☐ Perceptual Difficulties ☐ Neglect ☐

Details:

_____
_____
_____
_____
_____

Vision:

Visual Acuity: _____

Visual Perception: _____

Visual Field Deficit: Yes ☐ No ☐

Details: _____

Oculomotor Deficits: Yes ☐ No ☐

Details: _____

Current Occupational Therapy Goals:

Standardised Assessments Completed & Results:

Equipment List Required for Discharge:
(Please provide exact details/measurements where required)

(Please note that any additional equipment needs not already provided by the HSE must have agreed funding prior to acceptance to rehab facility)

Brampton
Care & Rehabilitation Centre

SPEECH AND LANGUAGE THERAPY REPORT

Print Name: **Contact Details**

Date of Acute Onset:

Description and location of Cerebral Injury:

Cause of Injury: ☐ **Road Traffic Accident** ☐ **Fall** ☐ **Sports** ☐ **Other** _____

Previous Speech, Language, or Swallowing Diagnosis:

__ Aphasia
__ Apraxia of Speech
__ Cognitive Communication Disorder
__ Dysarthria (Motor Speech Disorder)
__ Dysphagia (Swallowing Disorder)
__ Laryngectomy (Partial/Total)
__ Neurogenic Stuttering
__ Voice Disorder
__ Vocal Fold Paresis/Paralysis
__ Other _____

Instrumental / Diagnostic Procedures completed: (Please send copy of report)

__ Clinical Swallow Evaluation
__ Cognitive Evaluation
__ Fiberoptic Endoscopic Evaluation of Swallow (FEES)
__ Modified Barium Swallow Study (MBSS)
__ Speech Evaluation
__ Videofluoroscopic Swallow Study (VFSS)

Current / Previous Respiratory conditions: (Check all that apply)

__ Asthma
__ Chronic Obstructive Pulmonary Disease (COPD)
__ Cystic Fibrosis
__ Dyspnea
__ Emphysema
__ Obstructive Sleep Apnea (OSA)
__ Pneumonia
__ Other _____

Current / Previous diagnosis of Swallow Disorder: Yes/No

Current IDDSI Texture Diet: __ Regular (RG7) __ Soft & Bite Sized (SB6) __ Minced & Moist (MM5) __ Pureed (PU4) __ Liquidised (LQ3)

Current IDDSI Liquid Diet: __ Regular / Thin (TN0) __ Slightly Thick (ST1) __ Mildly Thick (MT2) __ Moderately Thick (MO3) __ Extremely Thick (EX4)

Current of Previous Tracheostomy: Yes/No

Date of Placement: _____ **Date of Decannulation:** _____

Name and Contact of Physician who completed Tracheotomy: _____

Current Tracheostomy Type / Size
TT Cuffed / Cuffless:
PMV: Yes/No **Secretion Management:** __ Good __ Fair __ Poor

Communication Concerns: Yes/No
Detail concerns:

Communicates by: __ Speaking __ Gesturing __ Sign Language __ Writing __ AAC Device

Northwick Park dependency scale if applicable:

Rehabilitation Complexity Scale Score if applicable:

PSYCHOLOGY REPORT

Please include even if psychology assessment has not taken place

Print Name: **Contact Details**

Was the patient seen by psychology or psychiatry during admission? **Yes** ☐ **No** ☐ **Date last seen:** **Name of provider:** **Contact information:** **Details of assessment or treatment provided:** **Is a report attached?** **Yes** ☐ **No** ☐
Please detail any previous history of mental health problems, including depression, anxiety, psychosis, substance abuse?
Please list any previous Mental Health Services involvement (if known):
Please state any concerns regarding patient's mental health, including low mood, anxiety or behaviour changes:
Current psychology goals:

Please outline onward referrals completed:

Please attach most recent blood tests and any relevant reports

This form and attachments should be returned to rehab@brampton.ie