Patient Name: DOB:

NHS
Cheshire and Merseyside
Rehabilitation Network

Community Specialist Rehabilitation Service

Referral Criteria

The Cheshire and Merseyside Rehabilitation Network offers community service to patients with complex rehabilitation needs that require **two disciplines or more**. There are two community teams:

Team	Registered GP	Disciplines Available
Locality 1	Patient must be registered with a GP in: St Helens or Knowsley	Physiotherapy Occupational Therapy Clinical Psychology Vocational Rehabilitation
Locality 2	Patient must be registered with a GP in: Liverpool South Sefton or Southport & Formby	Physiotherapy Speech and Language Therapy Occupational Therapy Clinical Psychology Vocational Rehabilitation

Age: 18 years and over. Any referrals for individuals aged 16–17 where specialist services are not available to meet their needs should be discussed with the community service prior to submitting the referral form.

Diagnosis: The service accepts patients based on rehabilitation need rather than diagnosis. The patient must have clear and achievable rehabilitation goals and demonstrate a commitment to achieve these. **The patient must be aware of their medical diagnosis. This includes patients who have 'medically unexplained symptoms'**.
The service cannot accept patients for the management of a tracheostomy weaning programme.
Details of any investigations and imaging must be detailed in the referral.

Consent: The patient must be made aware of the referral to the service.

Disciplines Involved: In order to be considered for the service the patient must require input from two or more disciplines that are available, each with identified rehabilitation goals.

DNA policy: If a patient is absent for 2 therapy sessions they will be invited to contact the service to arrange a new appointment. If this is not done within two weeks the patient will be discharged from the service and their GP informed.

Triage: All referrals must be made via the referral form by a registered healthcare professional. Forms that do not contain sufficient information will be returned to the referrer and the patient will not be considered for acceptance to the service. In order to facilitate the triage process and reduce delays please ensure that the criteria for referral is met and as much information included on the referral form. Please contact the service to discuss the referral if you have any questions prior to submitting the form

Please note, this is not a crisis management community service and we cannot respond to patients who need an urgent visit on discharge from hospital. Where there are other pre-existing services/pathways available to meet their needs (e.g. Early supported discharge, stroke services, palliative care, community team service, community mental health team) the referrer will be signposted to such services.

To discuss a referral please contact the community specialist rehabilitation team: 01744 457 332

Patient Name: DOB:

Community Specialist Rehabilitation Service. Locality 1

Referral Form. ***CONFIDENTIAL***

NHS Cheshire and Merseyside Rehabilitation Network

Please ensure *all* sections are completed— uncompleted forms will be returned to the referrer and not processed

Patient Details: Title: …… Sex: M / F Date of Birth …… Age:……..

Surname: ……..

First Name: …… NHS Number: ……...

Address: …….. Telephone Number: ……..

…… Mobile Number: ……..

……Post Code: ……. E mail: ……..

Languages spoken (list first as main language) : ……..…… Translator Needed? Yes □ No □

Next of Kin: ……..

Relationship: ……..

Address: ……..

……..……..

……Post Code……..

Telephone……: ……..

GP Name: ……...

Practice: ……...

Address: ……..

……

……Post Code: ……

Telephone: ……..

Past Medical History:

Mental Health Background:

Please attach medication list □ **Known drug allergies:**

Medical Diagnosis pertaining to this referral:

Is patient aware of diagnosis? Yes □ No* □ If 'no' please state reason:

History of presenting illness or injury:

Relevant medical investigations (please include CT / MRI and relevant X-Ray reports) to date:

Brief summary of input patient has received to date (please attach discharge report if available)

If patient is currently an in-patient, what is the predicted date of discharge? ____/_____/_____

Patient Name: DOB:

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Please identify the disciplines required and the <u>identified rehabilitation goals:</u>
(please supply on additional page if required)

☐ **Physiotherapy**

1

2

3

☐ **Occupational Therapy**

1

2

3

☐ **Psychology**

1

2

3

☐ **Vocational Rehabilitation**

1

2

3

Patient's employment status and job prior to illness ……...

Patient Name: DOB:

Equipment: Please list all current equipment that patient has (for mobility, ADLs and communication) and those which have been ordered.

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Other disciplines involved:

Social Services □ District Nurse □ Social Package of care □ (Frequency of visits: ……)

Dietitian □ Speech and Language Therapist □ **Consultant** □ (Name: ……) Orthotics Team □ IMCA □

Other: ……..

Patient's Housing status:

□ Bungalow □ House □ Flat □ Care Home □ Sheltered Accommodation □ Hostel □ Homeless

Specific information about access: (key safe, unable to answer door etc)

……

……

Risk for home visit: Are there any known risks to the patient or family/friends that the team should be aware of prior to visiting? Please detail any **environmental risks** and **risk to self/ others** (please include any details regarding possible drug, alcohol and mental health concerns)

Environmental Risk

……
……..

Risk to Self/ others

……

……

Does the patient have caring responsibilities / dependents? Yes □ No □

If yes, please give details: ……

……

……..

Referrer details:

Name:…….. Profession: ……

Address: ……. Telephone Number: ……

……. Email address: ……..

……Post Code:……

SIGNED: …… DATE: ……

Send to: *Community Specialist Rehabilitation Service, Cheshire and Merseyside Rehabilitation Network*

St Helens and Knowsley Division , Bridgewater Community Healthcare Foundation NHS Trust

The Bridges Learning Centre, Crow Wood Lane, Widnes, WA8 3LZ ***Or FAX:*** 0845 1131333

Please do not email your referral to individual clinicians.

OFFICE USE:

DATE RECEIVED: **LOCALITY:** **TRIAGE DATE:** **ACCEPT:**