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| **Community Therapy Referral** |
| **Referral Date:**  |  | * **Consent to referral**
 |
| * **Neighbourhood Team Therapy** – (No care needs or restarting existing package of care)

Send as below |  | * **Home First Therapy**  - (If referral to Adult Social care has been made also)

Send as below plus copy to Complex Discharge team (will replace therapy goal sheet) |
| **Email:** **duty.therapy@nhs.net**  **Telephone: 01432 842244 Fax: 01432 347689****Post:** **Referrals Hub, Vaughan Building, Wye Valley NHS Trust, Ruckhall Lane, Herefordshire HR2 9RP** |
| **Service Required:*** **Physiotherapy** (Housebound Only)
* **Occupational Therapy**
* **Complex Moving & Handling**
 |
| **Patient Name & Address:****Date of Birth:****NHS No:** **GP Surgery:** **Telephone Number:** **Next of Kin contact:**  | **Alerts & Allergies:** **Key safe / key safe number:** **Can they be visited alone? Yes / No****Any pet to be aware of? Yes / No** **Concerns with MCA Yes / No****Safeguarding in place Yes / No****DOLS in place Yes / No**  |
| **Recent admission details:** **Admission date: EDD:** | **Current Location of Patient:** |
| **Name & designation of referrer:**  | **Referrer contact No:** |

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| **Reason for referral:****Any other referrals made –** (e.g. Home First, Parkinson’s, neuro team, brain injury team, DN, Falls clinic)**Known to social care:** yes / no **Existing care package details -** ASC**/**Private**Does the patient pay council tax to Herefordshire?** Yes / No |
| **Current and Relevant Past Medical History:****(To include current diagnosis, any surgery, precautions and contraindications):**\*\*Medical summary attached – yes / no  | **Current and previous functional levels** **How does the patient walk? Do they use an aid?** |
| **How does the patient transfer on/off the bed/chair/toilet?** |
| **Any concerns with pressure areas:** |
| **Any problems or help needed with getting get washed and dressed:** |
| **Current medications list:** | **Any problems or help needed with preparing meals:** |
| **Any problems or help with taking their medication:** |
| **Any equipment already in situ (i.e. toilet seats, perching stools, commode, rails)** |
| **Accommodation details – (type / tenure)** |
| **What goals does the patient want to achieve?** |

**Please ensure this form is completed in full.**