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### REFERRAL FOR INPATIENT EAST KENT NEUROREHAB UNIT (EKNRU)

**Exclusion criteria**

Please note we cannot accept the following patients:

* Patients under mental health section.
* Patients requiring a Level 1 or 2a rehab unit
* We are unlikely to accept patients who require secure accommodation to ensure their and / or others’ safety but this will be assessed on an individual basis.
* We do not accept patients who have a GP outside of   
  East Kent. Please see our catchment areas below.

**Referral criteria**

* There is evidence of organic neurological aetiology.
* The patient’s impairments are having a significant effect on their ability to participate in society and fulfil social roles.
* The patient’s need for rehabilitation is more intensive than can be provided by their local ICT (i.e. more than one hour per day, five days per week).

***NB: If the above criteria are not met, please contact EKNRU, prior to making your referral.***

EKNRU has 19 beds, for the large catchment area of East Kent (patients with GPs in Ashford, Tenterden, Romney Marsh, Folkestone, Dover, Thanet, Herne Bay, Whitstable, Sittingbourne)

The MDT assess each referral thoroughly, to ensure the patients accepted on to the waiting list are suitable for this Level 2B rehab unit.

All sections of this form need to be completed, to prevent delays to the admission process. This is an MDT referral form and there is an expectation that all members of the MDT contribute as much detail as possible.

**Please be aware we have a waiting list; a referral does not guarantee a place on this. The MDT will consider the referral and respond at the earliest opportunity. The outcome will be communicated by SUNRISE for EKHUFT inpatients, and by email to the referrer, for other referral sources.**

The main New Referrals Meeting takes place at 11:30 on Tuesdays, so submitting a referral before 10:30 on Tuesdays is recommended

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|  | | **PATIENT DETAILS** | |
| Name  NHS NO: |  | | **Date of Birth** |
| Home address |  | | **Contact telephone No:** |
| Current location of Patient |  | | Ward:  Ward contact no: |
| GP name |  | | GP Address:  GP contact no: |
| Next of Kin  Relationship to Patient |  | | NOK details: |

**Names of Referrer and secondary contact (in case of absence):**

**TREATMENT TEAM**

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| **ALL INFORMATION BELOW IS ESSENTIAL AS PATIENT WILL NOT BE ACCEPTED UNTIL ALL QUERIES HAVE BEEN RESOLVED** | **Name** | Contact Details |
| Lead medic (Responding to queries) |  |  |
| Lead nurse |  |  |
| Lead therapist |  |  |
| Oncology Consultant (if applicable? |  |  |
| Is the patient for Resus | Yes  No |  |

**PLEASE ENSURE DETAILS OF THE LEAD MEDIC AND WIDER MDT TEAM ABLE TO RESPOND TO QUERIES RELATING TO PATIENT DIAGNOSIS AND ONGOING CARE HAVE BEEN INCLUDED ON THIS FORM AS PATIENT WILL NOT BE ACCEPTED UNTIL ALL QUERIES HAVE BEEN RESOLVED.**

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| **MEDICAL** | |  |
| Date of onset |  | History of present condition and ongoing plan |
| Diagnosis |  | **Full past medical history / comorbidities** |
| **Oncology Patients**  Is patient/ NOK aware of diagnosis/prognosis? | Yes  No | **Please provide details of care plan including further Oncology Follow ups:** |
| Please provide details of CT / MRI results, including dates |  | Are there any outstanding / pending results or investigations? Yes (Please specify) No |
| Can the patient maintain their own airway? | Yes  No | Does the patient have any VRE or CPO, please indicate status: |

**Insufficient detail regarding medical investigations/onward medical plans is likely to delay acceptance on to our admission list**

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| **Please list any medications below and/or attach a copy of a current drug chart** | | | |
| **Medication name** | **Dose** | **Frequency** | **Route** |
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*(Please continue on a separate sheet if necessary)*

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| **NURSING** | |  | |  |
| **Nutrition** | |  | |  |
| Is the patient’s swallow intact? | Yes  No | | Do they require NG / PEG feeding? | Yes  No |
| Do they have any specialist nutritional needs? | Yes  No | | Current Diet (please indicate if ND/ NF or current diet/fluid level) |  |
| Current Weight/ if specialist or Bariatric Equipment req’d please specify: |  | |  |  |
| Continence |  | | Pressure areas |  |
| Bowel: | Bladder: | | Pressure areas ( if yes please indicate) | Yes  No |

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| **COGNITION and COMMUNICATION (PLEASE SCAN AND ATTACH COPIES OF ALL PT/OT ASSESSMENTS AND REPORTS)** | | | |
| Does the patient have the mental capacity to consent to this admission? | Yes  No | Does the patient present with cognitive impairment as a consequence of the neurological event? | Yes  No |
| Did the patient have pre-existing cognitive impairment? | Yes  No | Have any cognitive assessments been completed? If so, please state the name of the test and scores. | |
| Does the patient have communication needs unrelated to their neurological needs?  (eg needs interpreter, BSL) | Yes No |  | |

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| **MENTAL HEALTH AND SUBSTANCE ABUSE** | | | |
| Does the patient have any current mental health difficulties? | Yes  No | Did the patient have pre-existing mental health difficulties? | Yes  No |
| Does the patient have a substance abuse history? | Yes  No | If the answer to any of these questions is **YES**, please provide further details: | |

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| **BEHAVIOUR AND RISK** | |
| Does the patient pose a **Current** **Risk** to themselves or others? | Yes  No |

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| **At ANY TIME in the past month has the patient** | | | |
| Required 1:1 supervision to keep them safe | | Yes  No | |
| Exhibited physical aggression? | Yes  No | Attempted to leave the ward against medical advice? | Yes  No |
| Is there a history of pre-existing aggression or challenging behaviour? | Yes  No | **If yes to any of the above, please give details, current status and reasons below** | |

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| **SOCIAL SITUATION** | |
| Does the patient have a support network social suitable discharge destination? Please provide details: |  |

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| **THERAPY (PLEASE SCAN AND ATTACH COPIES OF ALL PT/OT ASSESSMENTS AND REPORTS)** | | | | | |
| **Mobility** | | | | | |
| Does the patient require a wheelchair? | | Yes  No | | Has a wheelchair referral been sent? | Yes  No |
| Does the patient require any walking aids? | | Yes  No | | Does the patient require assistance with transfers? | Yes  No |
| **If yes to any of the above, please give details, below:** | | | | | |
| Does the patient have abnormal tone? | | Yes  No | | Does the patient require any splints? | Yes  No |
| **If yes to any of the above, please give details, below:** | | | | | |
| **Has a referral been made to a specialist unit? (e.g. Stoke Mandeville, Frank Cooksey)** | Yes  No | | **If yes, please provide details below:** | | |

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| **THERAPY HANDOVER (PLEASE ATTACH COPIES OFF ALL PT/OT ASSESSMENTS AND REPORTS)** | |
| **Speech and language** | **Psychology** |
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| **Physiotherapy –** Please **detail pre-morbid abilities, progress made and current level** |
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| **Occupational therapy –** Please **detail home situation, previous abilities, progress made, current level and scan relevant reports** |
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| **REHABILITATION GOALS** | |
| **Please list the patient’s rehabilitation goals below** | |
| Speech and language | Psychology |
| Physiotherapy | Occupational therapy |

*(Please continue on a separate sheet if required)*

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| **ADDITIONAL INFORMATION** |
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As a Trust we need to be able to identify, without discrimination, all patients who may be liable for charges as soon as possible. Being registered with a GP or having an NHS number does not give a person automatic entitlement to access free NHS hospital treatment. **Entitlement to free NHS care is based on UK Residency.** Therefore, when patients are referred, the following **baseline questions** should be asked:

* **Where have they lived in the last 6 months?**
* **Are they a UK/EEA national?**
* **If not then from which country are they from?**

**Please e-mail completed form to: ekhuft.eknrureferrals@nhs.net**

For further information please contact

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