COMMUNITY REHABILITATION SERVICES
REFERRAL FORM B

ADULT REHAB TEAM ❒ NEURO REHAB TEAM ❒ FALLS TEAM ❒ SALT ❒ (✓)

✳ ***In order to prioritise referrals and avoid any delay in treatment please ensure that all sections are completed*** ✳

Patient Name……NHS No……D.O.B.. ……

Address……

……Tel: No……

G.P……..Consultant……

Next of kin……Contact No……

SOCIAL CIRCUMSTANCES *(please tick)*

Lives alone ❒ With Partner ❒ With Family ❒ Rest Home ❒ Nursing Home ❒ Temporary ❒ Permanent ❒

RISK ASSESSMENT – *To ensure the safety of any visiting Therapist / Patient, please indicate any risk (✓)*

Violence ❒ Aggression ❒ MRSA ❒ Other infection ❒ Alcohol abuse ❒ Smoker ❒ Environment ❒

COMMENTS

IS PATIENT HOUSEBOUND? Yes ❒ No ❒

CAN PATIENT BE CONTACTED DIRECTLY? Yes ❒ No ❒ ……

HAS PATIENT BEEN REFERRED TO ANY OTHER AGENCIES? ……

DIAGNOSIS / REASON FOR REFERRAL

DETAILS OF HOSPITAL ADMISSION (if applicable)

DATE OF ADMISSION	DATE OF ONSET/OPERATION	DATE OF DISCHARGE	HOME □ OTHER □ *(specify)*

PREVIOUS MEDICAL HISTORY

MEDICATION

Patient Name……NHS No…….

FALLS HISTORY	**No falls in last 4 weeks**	**No falls in past 3 months**	**No falls in last 12 months**
Pattern of falls (time of day, mechanism, equipment)		**Injuries?**	

CURRENT STATUS

	PREVIOUS	**CURRENT**	**REALISTIC GOAL**
TRANSFERS / MOBILITY (incl aids) / STAIRS			
ADLs (domestic chores/personal care/hobbies)			
COGNITION			
COMMUNICATION			
SWALLOW FUNCTION			
ANY OTHER COMMENTS / PATIENT SPECIFIC PROBLEMS OR GOALS			

REFERRED BY *(BLOCK CAPITALS)*……

DESIGNATION……

BASE …… …….. SIGNATURE……

CONTACT No ……..…….. DATE……..

West Lancashire Area
Hilldale, ODGH, Wigan Road, Ormskirk, L39 2JW
Adult Tel: 01695 588300
Neuro Tel: 01695 588305
Falls Tel: 01695 588193
SALT Tel: 01695 588268
Adult/Falls Fax: 01695 588415
Neuro/SALT Fax: 01695 588686

Triage Date	**Priority:** 48 hours □ 2 weeks □ 6 weeks □ Stroke Pathway □	
Triaged By	**Triage code**	**Estimated Date To Be Seen**