Referral for Specialist Rehabilitation Services at the National Rehabilitation Hospital

Referrals cannot be processed unless this form is fully completed by the Referring Team and full clinical information is attached

1. Rehabilitation Programme

1. Please tick as appropriate ✓

- Brain Injury Programme ☐
- Spinal Cord System of Care Programme ☐
- Prosthetic, Orthotic, Limb Absence (POLAR) ☐
- Paediatric Family-Centred Programme ☐

Patient Details

Surname:

Forename:

Also known as (if applicable):

Address:

DOB: __ __ /__ __ /__ __ __ __ **Gender:**

Tel (Home): **Mobile:**

Nationality:

First Language: **Interpreter required:** Y N

Occupation: **Religion (if known):**

Patients' Contact person or Next of Kin

The 'Contact' person should be contactable regarding the Patient's Appointments at the NRH

Contact Name:

Address:

Tel (Home): **Mobile:**

Relationship:

Next of Kin (if different From above)

Name:

Address:

Tel (Home): **Mobile:**

2. Clinic or Service

2. Please tick as appropriate ✓

- Inpatient Services ☐
- Outpatient Services ☐

Details of Referrer or Agency

Referring Consultant or Healthcare Professional:

Contact Details:

Referrer's Registration No Or Agency Stamp:

Referral Outcome to be sent to:

Signature/Date:

GP Details

Name:

Address:

Contact Details:

Medical Card Details

Medical Card: Yes ☐ No ☐ M.Card has been applied for ☐

Medical Card No:

Expiry Date:

Other Important Information

Patient's Current Location or Ward:

Please confirm that Patient or Family have been advised of this referral? ✓ Yes ☐

Does patient have a DNR order? Yes ☐ No ☐