NATIONAL REHABILITATION HOSPITAL

<u>OUT-PATIENT</u> REFERRAL FORM FOR ADULT PROGRAMMES (excl. POLAR)

All referrals must be sent with detailed medical reports and a current list of medications. Incomplete referrals, without this information, will be returned to the referrer.

Please email / send this completed form to: **referrals@nrh.ie** or by post to the Central Referrals Office, NRH, Rochestown Avenue, Dun Laoghaire, Co Dublin A92 E2H2

Brain injury	**Stroke**	**Spinal cord system of care** (SCSC including critical illness neuropathy, peripheral neuropathy)

1. Patient demographic and referrer details

Family name:	**Given name:**	**DoB:**	**Gender:**
Current Location:			
1:1 supervision required? Yes No		**Residency / visa status?**	
Address: **Eircode:**		**Contact Number:**	
Primary language:		**Interpreter required:** yes / no	
Medical Card number and expiry date:		**Long term illness card number:**	
Referring Consultant and Hospital address: **Contact details :** (email / phone)		**Nominated contact person (NCP) name:** **Address:** **Phone numbers:**	
GP name:			
GP Address: **Phone number:**			

2. Medical details

Primary diagnosis / acute illness or injury / amputation (*must include date of onset)

Other / background diagnoses:

***** if ESRD, attach details of dialysis provider(s) and schedules*****

Known allergies? Yes / No **Please give details**

DVT Prophylaxis? Yes / No **Please include in separate medications list**

History of primary diagnosis / recent injury or illness including all operative and non-surgical interventions and current medications
(attach medication list and all relevant reports including imaging, laboratory and operative reports):

Post-traumatic amnesia if TBI:

Please list HSCP and nursing interventions to date *(attach all available reports)*

If discharged from hospital, please list all community services involved:

3. Social and pre-injury information:	
Home supports:	**Mobility pre-injury**:
Employment:	**Driver:** yes/no **Driving Currently:** yes/no **Type of Licence:**

Social information						
Family Support	☐ Parent	☐ Children	☐ Spouse	☐ Partner	☐ Siblings	☐ Other
Living Situation	☐ Alone	☐ Parent(s)	☐ Partner	☐ Residential	☐Homeless	☐ Other
House Type	☐ Bungalow	☐ Apartment	☐ 2 storey	☐ Terraced	☐ Other	
Home Owner	□ Yes □ No					

4. Patient and family goals

5. Potential Risks					
☐ Seizures	☐ Risk of falls	☐ Forensic History			
Infection Status: ☐ C-Diff ☐ VRE ☐ MRSA ☐ Hep B ☐ Hep C ☐ HIV ☐ Other? *Please specify*					

Doctor's signature:	
IMC number:	
Date:	
Phone number of contact Dr / nurse / HSCP	