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Description automatically generated with medium confidence

**Hull and East Riding Community Rehabilitation**

**Referral Form**

**For Physiotherapy/Occupational Therapy**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | | Date of Referral: | | | |
| Job Title: | | | | | | | | | |
| Address & contact number/email of referrer: | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | |
| Registered GP: | | | | GP Practice Address: | | | | Hull | East Riding |
| Telephone Number: | | | |  | | | |  |  |
| Title: | Forename: | | | Surname: | | | | Known as: | |
| Date of Birth: | | | | NHS Number: | | | | | |
| Gender: | | | | Ethnicity: | | | | | |
| Religion: | | | | | |
| Address: | | | | | | | | | |
| Patient Home Telephone Number: | | | | Patient Mobile Number: | | | | | |
| Preferred contact number: Home  Mobile | | | | Email address: | | | | | |
| Lives alone/carers/nursing home/  residential home | | | | Next of Kin/Carer/Emergency contact: | | | | | |
| Consent to contact via SMS | | | | Yes | No | | | | |
| Consent to contact via SMS & Email | | | | Yes | No | | | | |
| Consent to share medical information: | | | | Yes | No | | | | |
| Translator required: | | Yes | | No | Language required\*: | | | | |
| Accessible information needs: | | Yes | | No | Detail needs: | | | | |
| Diagnosis: | | Client aware of diagnosis? | | Yes | No | | | | |
| **SUPPORTING INFORMATION** | | | | | | | | | |
| Is there a Lone working risk? | | | Yes | | | | No | | |
| Is there a Safeguarding risk? | | | Yes | | | | No | | |
| Has the patient given consent for the referral? | | | Yes | | | | No | | |
| Any concerns re Mental Capacity? | | | Yes | | | | No | | |
| **ReSPECT** document in place? | | Yes | No | | | | **(If yes give details)** | | |
| Smoking: | | Yes | No | | | | Don’t know | | |
| MEDICAL HISTORY | | | | | | | | | |
|  | | | | | | | | | |
| Profession Required: Physiotherapy  Occupational Therapy | | | | | | | | | |
| **Reason for referral: (The reason for referral needs to be *clearly detailed*. Insufficient information will result in the referral being returned)** | | | | | | | | | |
| **EXCLUSION CRITERIA**  **…**are under 18 years old  …are presenting with difficulties which are due to a learning disability (refer to The CTLD Team)  …need to be seen for equipment provision only (refer to Social Services Occupational Therapy)  …need to be seen for provision of splints only  …need an MSK Physiotherapy assessment and are able to attend a clinic (please refer to MSK)    *If you would like advice on where to refer such clients, please ring the number below and we will try to help…* | | | | | | | | | |
| **To make a referral please send via email to:** [**chcp.247111@nhs.net**](mailto:CHCP.247111@nhs.net) **or contact Tel – 01482 247111**  \* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\*** | | | | | | | | | |