**For Office Use: Referral No: Category:**

REFERRAL TO THE WEST LOTHIAN COMMUNITY REHABILITATION

**AND BRAIN INJURY SERVICE**

|  |  |  |
| --- | --- | --- |
| Surname: | Address:Post Code:  | Sex: Ethnicity:  |
| First Name: | DOB: Age:  |
| Marital Status: | Telephone: | CHI No: **SWIFT:** |

REFERRING AGENT DETAILS:

|  |  |  |
| --- | --- | --- |
| Name of Referring Agent: | Designation of Referring Agent: | Date of Referral: |
| Address:  |
| Tel No:  |

NEXT OF KIN/OTHER CONTACT:

|  |
| --- |
| Name: Relationship to Client:  |
| Address:  |
| Tel No:  |

DIAGNOSTIC INFORMATION:

|  |  |
| --- | --- |
| Diagnosis/Presenting complaint: | Date of Onset: |
| Last Hospital Admission & Discharge Dates If Appropriate:Name of Hospital(s) / Ward(s):Details (inc surgical intervention, GCS and CT results for brain injury referrals): | Past Medical History: |
| Current Medication: |
| Any allergies: Detail: |

#### ELIGIBILITY CRITERIA

#### Over 16 years of age

**Resident in West Lothian**

**Have an acquired neurological condition**

**Medically Stable**

**Potential to improve level of functioning**

**If appropriate, have a pre-planned package of care in place and have all necessary equipment for discharge from hospital.**

**OTHER AGENCIES CURRENTLY INVOLVED:**

|  |  |  |
| --- | --- | --- |
| Name | Agency | Address and Telephone |
|  |  |  |
|  |  |  |

**OTHER SERVICES INVOLVED OVER THE LAST 12 MONTHS:**

|  |  |  |
| --- | --- | --- |
| Name | Agency | Address and Telephone |
|  |  |  |
|  |  |  |

**IS THE PERSON AWARE OF THIS REFERRAL YES/NO**

**HAS REFERRAL BEEN MADE TO COMMUNITY O.T. YES/NO**

**If yes, please detail**

**HAS A SINGLE SHARED ASSESSMENT BEEN COMPLETED YES/NO**

**If yes, please forward copy.**

**IS THERE ANY REASON WHY A LONE WORKER SHOULD YES/NO**

**NOT VISIT THIS HOUSEHOLD**

**If yes, please detail**

### REFERRAL INFORMATION:

### Please complete all of the following:-

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| --- |
| **PHYSICAL PRESENTATION -** Please detail client’s transfers, mobility, upper limb function,  walking aids, etc.**IS THE CLIENT AT RISK OF FALLS?** |

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| --- |
| **INDEPENDENT LIVING SKILLS -** Please detail client’s Personal and Domestic Activities of Daily Living, Community Living Skills and any Support required. |

|  |
| --- |
| **COGNITIVE, BEHAVIOURAL** Please detail any problems in these areas.AND EMOTIONAL ISSUES -  |

|  |
| --- |
| **COMMUNICATION AND** Please detail any difficulties with speech, language (written or **SWALLOWING -** spoken), voice and swallowing. |

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| --- |
| **SOCIAL CIRCUMSTANCES** – Please give information regarding social network, leisure and  work pursuits and social integration.Are there any spiritual, religious, or cultural matters relevant to the provision of Service?:- |

|  |
| --- |
| **CARER / FAMILY STRESS -**  Please detail any issues or support needs. |

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| --- |
| **FINANCE / ACCOMMODATION -**  Please detail any problems in these areas e.g. difficulties With money management / benefits check may be  required /unsuitable accommodation / adaptations  required. |

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| **ADDITIONAL INFORMATON -**  Please detail any further relevant information which has not  already been covered. |

Please include any relevant reports / letters (Hospital Discharge Reports, Clinic Reports, Medical Information, etc.)

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| --- |
| REHABILITATION - Please specify what you hope your client will realistically achieve through GOALS IDENTIFIED: involvement with the Community Rehabilitation & Brain Injury Service.**Therapy Disciplines Requested: PT OT SALT Psychology**  |

**Please return completed form to: CRABIS, Strathbrock Partnership Centre, 189A West Main Street, Broxburn, EH52 5LH**

**or email to** **loth.crabiswl@nhslothian.scot.nhs.uk**

**For Further Information Please Telephone: 01506 524 149 (physio/OT referrals)**

**0131 537 9128 (neuropsychology referrals)**

**01506 524 191 (SLT referrals)**