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DOMICILIARY/MEDICAL PHYSIOTHERAPY REFERRAL FORM

**Domiciliary**

**Medical O/P **

INTRA AHP SERVICES & SERVICES OUTWITH WEST LOTHIAN SHOULD USE THIS FORM TO REFER TO THE PHYSIOTHERAPY TEAM:

This form should be completed IN FULL and emailed to [sjh.domiphysio@nhslothian.scot.nhs.uk](mailto:sjh.domiphysio@nhslothian.scot.nhs.uk), you will receive a confirmation on receipt and action of the referral.

Any queries please email the domiciliary box as above.

**PATIENT / CLIENT DETAILS**

|  |  |  |
| --- | --- | --- |
| Surname: | Address: | Sex: |
| First Name: | DOB: |
| Mr/Mrs | Telephone: | CHI No: |

NEXT OF KIN/OTHER CONTACT:

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

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

REFERRING AGENT DETAILS:

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

DIAGNOSTIC INFORMATION:

|  |  |
| --- | --- |
| Reason for referral | Date of Onset/Hospital admission and d/c: |
| HPC: | Past Medical History: |
| Cognition/communication issues: | Current Medication: |

**OTHER AGENCIES CURRENTLY INVOLVED/REFERRALS:**

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

**CARE PACKAGE DETAILS (inc. home care / day care Number of carers)**

|  |  |
| --- | --- |
| **Reablement involved Yes/No** | **POC Yes/No** |
| **Details (inc. POC provider, care provided, number of carers. Advice given to reablement re: HEP etc)** | |

ACCOMMODATION DETAILS (incl. access- steps front/back/internal – are rails in place)

|  |  |
| --- | --- |
|  | |
| Any Concerns about a lone worker visiting this household? | Yes/No |

|  |  |  |
| --- | --- | --- |
|  | **Previous** | **Current** |
| Mobility |  |  |
| Transfers |  |  |
| Stairs |  |  |

**INTERVENTION TO DATE**

|  |  |
| --- | --- |
| Details of advice and exercises given – frequency/reps/progressions | Any other information |

**REHABILITATION GOALS / AIMS OF TREATMENT**

|  |
| --- |
|  |