

## Adult Therapy Rehab Team: Referral Form

Surname: .....	Sex: M / F	D.O.B: .....	Age.....
First Name: .....		Ethnicity: .....	
Address: .....		NHS NO: .....	
.....		Tel No: .....	
..... Post Code: .....		Mobile No: .....	

Next Of Kin: .....	GP Name.....
Relationship: .....	Practice: .....
Address: .....	Address: .....
.....	.....
..... Post Code: .....	.....Post Code: .....
Tel No: .....	Tel No: .....

**Assessment required:**

Please attach any discharge summaries, EPR's from Hospital or relevant reports

**Physiotherapy** Yes

**Walking Aid** Yes

**Falls Service** Yes

Please attach falls referral form

Anticipated outcome of Therapy / Goals.....	Current services involved. Name / Tel No:
.....	Social worker: .....
.....	Social services OT: .....
.....	Care package: .....
Are there any risks we should be aware of? .....	District nurse: .....
.....	Other.....

Diagnosis: .....
Recent Hospital Admission: .....
Significant Medical history: .....
.....

Does the client live alone?	Yes	No
Is the Client housebound?	Yes	No
If no can the client get to Outpatients?	Yes	No
If yes please give reason for community referral.....		
Is the person having falls?	Yes	No
If yes how often? .....		
Can the client get to the toilet/ commode?	Yes	No
Does the client have a care package?	Yes	No
Is the carer managing?	Yes	No
Is the client aware of this referral?	Yes	No

Does the client have communication difficulties?	Yes	No	if yes please give details .....
Will an interpreter be required?	Yes	No	if so which Language?.....

Referrer name:..... Occupation:..... Service: ..... Address: ..... ..... .....Post Code: ..... Tel No: ..... Date: .....Signature.....	<p><b>Guide to referring</b></p> Referrals <u>NOT</u> appropriate for our team: <p>Provision of ADL equipment/home adaptations-  where this is the only or most significant need  or  Manual handling assessment or training  Send to <b>Social Services OT</b></p> <p>Assessment for wheelchair provision  Send to <b>Bowley Close Wheelchair Service</b></p> <p>Provision of hospital beds or pressure relief  Send to <b>District Nurse Team</b></p> <p>If client has a neuro condition  Send to <b>Neuro Rehab Team</b></p>
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**PLEASE RETURN FORM TO:**  
Adult Therapy Rehab Team  
Dulwich Community Hospital, East Dulwich Grove, London, SE22 8PT

**Tel: 020 7525 3483**  
**Fax: 020 8693 6760**

Please complete all sections of form and provide as much information as possible to avoid delay in processing.  
Incomplete referrals will slow down our ability to prioritise referrals as we will have to await information