KINGSTON INTERMEDIATE CARE SERVICE

FAX referral to: 020 8390 6923
(For Community I.V. Service referrals please phone referral: 020 8274 7088)
(Please note that Cedars Unit is a rehabilitation nurse-led/GP unit and we have no doctors on site)

Service Required (Please tick)	**In patient rehab bed**		**Services at Home (therapy, rehab asst)**		**Early Supported Discharge Team - Stroke * (ESDT)**		**District Nurse**		**Community Matron**	

Patient consented to referral?	YES / NO

Please ensure all sections are completed. Incomplete referrals cannot be actioned and will be returned. Once complete please fax to above number.

NHS Number				Discharge Coordinator	
Patient Name				GP	
D.O.B.		Tel No		Tel no.	
Address (including postcode)				N.O.K / Carer/sig other	
				Tel Home:	
				Tel Mobile:	
Lives with				Social Service Borough	

REASON FOR ADMISSION (inc investigations undertaken)	**PAST MEDICAL HISTORY**
Date of admission:	

If referring to ESDT please include details of CVA and any relevant investigations:

REASON FOR REFERRAL TO ICS (please circle)

Mobility Personal Care Stairs Balance Outdoor skills Kitchen skills Confidence building

Palliative Care Wound care Diabetic care Catheter/Bowel Care Case Management (long term conditions) Other (please specify)

REFERRER DETAILS

Date of referral : **Time:** **Referral Source:**

Referrer name : **Referrer contact no:**

Current location of patient: **Estimated date of discharge:**

Date first visit required:

Patient Name: **D.O.B:**

This section need only be completed if patient requires rehabilitation in Tolworth or at home. Alternatively if there's an OT report available this could be sent with the form.

Please tick as appropriate: **I = Independent** **A = Assistance required** **D = Dependent**

PERFORMANCE AREA	Previous			COMMENTS (inc. equipment used)	Current			COMMENTS (inc. equipment used)
	I	A	D		I	A	D	
Mobility: (aids/supervision)								
Stairs								
Bed transfers								
Chair transfers								
Toilet transfers								
Bed mobility								
Washing upper body								
Washing lower body								
Dressing upper body								
Dressing lower body								
Meal preparation								
Snack/hot drink								
Feeding (any aids used)								
Laundry/house-work/shopping								
Medication (aids used)								

This section must be completed

HOME ENVIRONMENT (please circle)	ACCESS TO PROPERTY (please circle)
House Bungalow Flat Maisonette Sheltered Housing Residential Home Please give details of any known environmental risks to staff:	Patient able Patient unable Entry phone Warden Key safe Contact details for access (if different from home telephone)

CURRENT COMMUNITY SERVICES	
SERVICE INVOLVED	**COMMENTS**
Care Manager	Name: Contact Number:
District Nurse/Community Matron	Name: Contact Number:
Home Care (frequency)	
Meals on Wheels/Wiltshire Farm Foods	
Day Centre (specify name and frequency)	
Care Alarm (specify type)	
Other (specify)	

Patient Name **DOB:**

COMMUNICATION (circle as appropriate)						
Vision:		Hearing:		Aid worn?- L/R		Speech:
Preferred Language:				Interpreter required?- Yes /No		

CONTINENCE (This section relates to current ability)						**Additional information:**
Urine			**Faeces**			
	Day	**Night**		**Day**	**Night**	
Continent Incontinent			Continent Incontinent			

PSYCHOLOGICAL HEALTH (circle as appropriate)
Psychological issues: (eg anxiety, grief etc)-
Able to respond to information and follow instructions: Yes / No AMTS score:
Orientated: Yes / No Time/place/person (circle)

NUTRITION	**FALLS HISTORY**
Any nutritional issues? (inc. alcohol issues) BMI : MUST Score:	Date of last fall: Frequency:
SKIN/PRESSURE AREAS (circle)	**ANY OTHER ISSUES (eg pain, breathing problems, behavioural problems)**
Skin condition: Intact Broken Discoloured If broken or discoloured, indicate site – Current Waterlow Score:	

INFECTION STATUS (circle as appropriate)	
MRSA positive? YES/NO - If YES, site: Treatment information: Any other resistant organisms/disease? If yes, details including specimen results and any therapy:	C. Difficile positive? YES/NO If YES, treatment information:
Discharge Summary: attached / to follow (delete as applicable)	

Name:…… **Signature**: ……..

Designation:…..…… **Date**: ……..……..……