

Rehabilitation Unit Referral Form

PLEASE USE BLOCK CAPITALS IN BLACK INK

Full patient name:	Patient's current location:
Date of birth:	Referring Consultant or GP:
Address:	Doctor's contact address:
Postcode:	Postcode:
Telephone:	Telephone:
Proposed date of transfer:	Is the patient agreeing to transfer? YES <input type="checkbox"/> NO <input type="checkbox"/>
Planned duration:	If relevant, are family/carers aware? YES <input type="checkbox"/> NO <input type="checkbox"/>

Reason for referral:

Specific care/rehabilitation instructions:

Rehabilitation potential:

Relevant medical/surgical history:

Current medication:	

Consultant follow-up plans:	Consultant signature: _____ Date: _____

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TO BE COMPLETED FOR EACH REFERRAL

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Full patient name: _____

Physiotherapist's name: _____	Occupational therapist's name: _____
Telephone: _____	Telephone: _____

Relevant social history: _____ _____ _____	Functional status prior to admission: _____ _____ _____
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Physical intervention to date: _____ _____ _____	OT intervention to date: _____ _____ _____
Present difficulties: _____ _____ _____	Present difficulties: _____ _____ _____

Prognosis for Physio rehab: _____ _____ _____	Prognosis for OT rehab: _____ _____ _____
Recommendations: _____ _____ _____ _____ _____	Recommendations: _____ _____ _____ _____ _____

Other agencies involved: _____ _____ _____

Physio's signature: _____	OT signature: _____
Date: _____	Date: _____

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Full patient name: _____

- I understand that my doctor has arranged for me to be transferred to the Springdene Clinic for a course of intensive physical rehabilitation and I am in agreement with this plan.
- I further understand that when I arrive at the Springdene Clinic I will undergo a full assessment, and following this a course of therapy will be prescribed that may include individual physiotherapy, individual occupational therapy, hydrotherapy, and group therapy sessions. My programme may include activities to be carried out on my own.
- I appreciate that I am responsible for the cost of my care during my stay at the Springdene Clinic and that a refundable surety of £650 and a minimum of one week's fees (at the agreed rate) will be required on arrival at the Clinic. Payment can be by credit/debit card or cheque. I confirm that I will be paying by:

Credit/debit card: Visa Barclaycard Switch American Express

Cheque

Patient's signature: _____

Date: _____

When completed, please combine with pages 1 & 2 and fax to Springdene Clinic at 0208 446 5050