NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

Allied Health Professions: Referral for Specialist Assessment
(Physiotherapy, Occupational Therapy, Nutrition & Dietetics, Speech & Language Therapy)
NB - NOT FOR PODIATRY
Please complete all sections of 3 page form – unsigned/incomplete referral forms will need to be returned

1. Patient Information

NHS Number:		GENDER:
SURNAME:	FORENAME:	MR/MRS/MISS/MS/OTHER
Previous Surname:	Date of Birth:	
ADDRESS:	Carer: [ ] Next of Kin: [ ] Name: Relationship: Address: Tel:	Home Tel No.: Mobile/Daytime Tel No:
Ethnic Group: Religion: Language: Interpreter required?	Does the patient live alone? Is the patient housebound? Any disability? Has the person agreed to this referral for a specialist assessment? If not able to, please clarify why:	
Diagnosis/Reason For Referral	Past Medical History (dates if possible)	Current Medication

2. General Practice Details

Practice Name & Address:

GP Code:
Practice Code:
Tel No:
Fax No:

Please give any information relating to the patient and home environment which may help to ensure the safety of the visiting therapist. (If none, please write 'none')

3. Referrer Details

Referred by (please print):
Designation:
Address (if different from practice details):

Tel:
Referrer Signature _____Date _____

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Patient's Name: …… D.O.B: ……..

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Need/Risk Area	**✓or n/a**	**Supporting Evidence (Please use Prompts)**
Chest/ Respiratory Problems		(Prompts: wheeze, tight chest, increase in shortness of breath).
Current Chest Infection/ Exacerbation		(Please circle appropriate answer to <u>each</u> question) Sputum retention? Y/N Sputum colour change? Y/N Decreased ability to cough? Y/N Seen by GP in previous 24 hours? Y/N OR Date last seen …….. Started on anti-biotics? Y/N Date course started……
Eating/Drinking/ Swallowing Difficulties		(Prompts: state occurrence, daily, weekly, monthly. Chest infections in last 6 weeks, 3 months, 6 months).
Biochemical/Weight Indicators		(Prompts: Rapid weight loss, BMI.) BIOCHEMISTRY RESULTS: eg Fastinglipids/glucose/HbA1c Does the patient require a domiciliary visit Y/N
Falls		(Prompts: Previous history of falls, date of last fall, frequency of falls, fracture or hospitalisation due to a fall. Need for home safety assessment or equipment)
		(Please circle appropriate answer to <u>each</u> question) Is there a history of any fall in the previous year? Y/N Is the patient on four or more medications per day? Y/N Does the patient have a diagnosis of Stroke or Parkinson's Disease? Y/N Does the patient report any problems with their balance? Y/N Is the patient unable to rise from a chair of knee height? Y/N
Mobility		(Prompts: <u>Specify</u> walking aids / wheelchair use, details of recent changes in mobility, current mobility level, indoor/outdoor)
Home Environment		(Prompts: Problems with stairs, transfers, bed, chair toilet, in and out of house, domestic tasks).

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Need/Risk Area	✓or n/a	Supporting Evidence (Please use Prompts)
Pain		(Prompts: Cause, severity, location of pain, disturbed sleep, disruption of essential daily activities, analgesia status, acute/chronic)
Continence		(Prompts: Constipation, problems with continence, does the patient have accidents with bladder or bowels)
Personal Care		(Prompts: Recent difficulties with washing, bathing, dressing, grooming – please describe)
Communication		(Prompts: Degree of difficulty, unable, with difficulty, verbal, non verbal)
Cognition		(Prompts: Problems with; Perception, Memory, Concentration. Mood alteration/disorder, loss of confidence)
Caring Responsibilities		(Prompts: State who is being cared for, detail the type, amount and intensity of care being given)
Work and Leisure		(Prompts: Describe the difficulties being encountered)
Other Agencies/Services involved		(Prompts: e.g. Mersey Care, Social Services, Voluntary. Please specify)

For audit purposes who do you feel would best meet this patient's needs?:-

Physiotherapy	☐	Occupational Therapy	☐
Falls Team	☐	Nutrition and Dietetics	☐
Speech & Language Therapy	☐	Unsure	☐

Please send this referral:
By Post to: Therapy Referrals, Queens Drive Health Centre, Moor Lane, Liverpool L4 6XG.
Tel: 0151 295 3400, Option 2 or 0151 296 7400/01 FAX 0151 296 7416
Email therapy.servicereferrals@nhs.net

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