Queen Victoria Hospital NHS
NHS Foundation Trust

Burns and Plastics Rehabilitation Form – Please use capitals

1. Patient information

Patient's name: ………………………………… Title: ……… Known as: ……………

Date of birth: ……………. Age: …….. Gender: ……… Ethnicity: ……………

NHS No.: ……………………… Religion: …………..

Home address: ………………………………… Telephone: …………………

………………………………… Post code: …………………

Discharge address if different: ……………………………
……………………………
……………………………

2. Referrer information

Name: …………………………………

Position: ………………………………

Consultant: ……………………………

Address: ………………………………

………………………………

Tel: ……………………………………

Fax: ……………………………………

3. General Practitioner details

Name: …………………………………

Address: ………………………………

………………………………

Tel: ……………………………………..…

Fax: …………………………………...

4. Referring Medical Practitioner/Consultant

If following the designated period of rehabilitation at the Queen Victoria Hospital burns rehabilitation service, this patient is unable for any medical or social reasons to return home/into a suitable placement I agree to readmit them to …………………………………..

Signature ……………………………………………. Title …………………………………

………………………………………………….

Name (please print) ………………………………… Date

………………………………………………….

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5. Presenting condition, diagnosis and treatment

Date of injury

Summary of injury and treatment

6. Summary of medical/surgical history

7. Results of any investigations and outstanding investigations

8. Current drug regime

(Please ensure 7 days supply is dispensed with patient)

9. Infection Status -

MRSA Status at time of referral

Site : …………………….……………………. Date: …………..

Current MRSA Status will be required at transfer

CDiff Status

……………………..……………………..

Any other swab results (date, location and sensitivities/resistance)

10. Nursing information

	Yes	No	Comments:
Dysphagia:	☐	☐	
Oral feeding:	☐	☐	
Nasogastric feeding:	☐	☐	
PEG feeding:	☐	☐	

Diet **soft** ☐ **puree** ☐ **normal** ☐
Fluids thickened ☐ **normal** ☐

Pressure sores:	☐	☐	**Waterlow score …………………..**
Special mattress:	☐	☐	
Bariatric equipment:	☐	☐	**Weight/BMI ………………………………**
Urinary incontinence:	☐	☐	If yes, occasional ☐ regular ☐
Urinary catheter:	☐	☐	
Faecal incontinence:	☐	☐	If yes, occasional ☐ regular ☐

Pain:
Disturbed sleep patterns:

Activities of daily living:

Personal care (Tick 1)		Eating/drinking	
Independent	☐	Independent	☐
Supervision from 1	☐	Supervision from 1	☐
Assistance from 1	☐	Assistance from 1	☐
Assistance from 2	☐	Assistance from 2	☐

Any other special nursing requirements i.e. dressings:

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11 Psychosocial care

Summary of Psychiatric history:

Has your patient seen a:	**Yes**	**No**	**Comments/Contacts:**
Psychological therapist**:**	☐	☐	…………………………
Psychiatrist	☐	☐	…………………………

Please send reports

12. Cognition and communication

First language: ……………………………………………………………………………

	Yes	No	Comments/Further details
Visual problems:	☐	☐	…………………………
Hearing problems:	☐	☐	…………………………

Other communication difficulties: ………………………………………………………

Cognition

	Yes	No	Comments/Further details
Disorientated at all times:	☐	☐	…………………………
Variable disorientation:	☐	☐	…………………………
Acute confusional state:	☐	☐	…………………………
Other:	☐	☐	…………………………
Dysphasia:	☐	☐	…………………………
Expressive dysphasia:	☐	☐	…………………………
Receptive dysphasia:	☐	☐	…………………………
Dysarthria:	☐	☐	…………………………
Other:	☐	☐	…………………………
Capacity to consent:	☐	☐	…………………………

……………………………………………………………………………..

If no, has Deprivation of Liberty Safeguards been undertaken including involvement of Independent Mental Capacity Advocate?...

13. Mobility and transfers

Transfers (Tick 1)
Independent ☐
Assistance from 1 ☐
Assistance from 2 ☐
Hoist ☐
Bedbound ☐

Mobility
Walking
Independent ☐
Supervision/help from 1 ☐
Supervision/help from 2 ☐
Aid used…………………..

Wheelchair
N/A ☐
Pushed in a wheelchair ☐
Independent ☐
Has own chair Yes/No
If yes, is it suitable Yes/No

Risk of falls Yes ☐ No ☐
Score …………

Any other information i.e. equipment…………………………………………………………………..

14. Social situation

Occupation: …………………………………… Marital status: ……..

Next of kin information: ………………………………Contact details…………………………………...

Other contact information (Optional) …………………Contact details …………………………………...

Comments/Further details

Lives alone ☐ Lives with Parents ☐ Lives with Husband/wife/partner ☐

Other ☐ Please specify: ………………………………………………………….

15. Type of residence and accessibility

Owner/occupied: ☐
Council/housing association: ☐
No fixed abode: ☐
Other: ☐ Please specify: ………………………………………………………..

Is this property habitable? Yes No
☐☐

Further information …………………………………………………………………………………

……

Does this patient have a:

	Yes	No	Name and contact number
Social Worker	☐	☐	……………………………………………………………………
Housing officer	☐	☐	……………………………………………………………………

16. Current rehabilitation input

	Yes	No	Comments:
Physiotherapy:	☐	☐	
Occupational Therapy:	☐	☐	
Speech & Language Therapy:	☐	☐	
Dietetics:	☐	☐	

Please attach reports from the therapists currently involved in the care of the patient, or arrange for them to be sent.

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17. Goals for rehabilitation

Current goals and anticipated goals for rehabilitation:

Anticipated length of stay for rehabilitation:……………………………………………………..

Thank you for completing this referral form please fax to the number below and telephone to confirm it has been received.

Phone: Burns therapy team -01342 414255
Burns ward - 01342414440
Fax: **01342 414104**
Website: www.qvh.nhs.uk