

Community Therapy

Referral Document for Care Homes

Please complete this document when referring a resident for community physiotherapy / occupational therapy. This will help to ensure that your resident receives appropriate and timely care.

Please consider acute medical cause for deterioration prior to referral to therapy.

Multifactorial falls prevention measures should be in place within your care home. Please ensure that these are being followed prior to referring to therapy.

|  |  |  |
| --- | --- | --- |
| **Service Requested (Please Tick):** | Physiotherapy | Occupational Therapy |

|  |  |
| --- | --- |
| **Name:** **Address:** **Post code:** **D.O.B.** **NHS No:** **G.P.:**  | **Date of referral**: **Name of referrer:** **Contact number:** **Consent for referral has been obtained from resident:** **Yes / No / Other (carer acting in best interest)****Relevant past medical history:** |
| **Key Worker:** (Please identify the name of a staff member who will act as key worker and support the resident in achieving their therapy goals). |  |
| 1. Has your resident been seen within the last 6 months for the same condition, and there have been no acute changes?
 | **No:** continue to the next question.**If Yes:** ***a new referral to therapy is not appropriate****. Please refer to self-management strategies of previous assessment*.  |
| 1. Is your resident able to follow instructions / actively participate in therapy sessions?
 | **Yes:** continue to the next question.**No:** please give further details below to support your referral before proceeding to question 3.  |
| 1. Does the resident meet one or more of the following criteria / reason for referral (please tick one or more boxes):
* New mobility aid assessment.
* **Person-centred** community specific goals for rehab have been identified, such as improving mobility or return to previous activities (led by the resident’s motivation and desire to achieve their specific goals). Please give further details regarding the person-centred goals for therapy:

Details of goals you have identified :-* Equipment provision. Please refer to the **Warwickshire Integrated Community Equipment Service Protocol** for responsibilities regarding provision and maintenance of equipment. All care homes should have a copy of this for guidance.
* Non-complex chest physiotherapy.
* Postural advice (this does **not include provision of specialist equipment / seating or orthotics / braces / splints / arm slings).**

Additional information to support your referral e.g., mobility aid / equipment requested:Further detail of problem to be addressed – pain, prev mobility etc.:- Please consider – HOW WILL THIS PATIENT BENEFIT FROM PHYSIO ? Please note that if this form is not completed in full, the referral will be rejected.   |

Please email this document to ispa@swft.nhs.uk