**Intermediate Care Referral**

**[Clashieknowe]**

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| **Email to SusanDuncan@aberdeencity.gov.uk/gram.dischargehub@nhs.scot** |
| All sections **MUST** be completed accurately for referral to be processed. | Incomplete forms will be returned. |
|  |  |
| **Service User Details:** |
| **Name:** |  | **Date of Birth** |  |
| **CHI No:** |  |
| **Address:** |  |
|  |  |
| **Post Code:**  |  |
| **Tel No:** |  |
|  |  |
| **Next of Kin** |
| **Name:** |  | **Relationship:** |  |
| **Address:** |  | **Tel No.:** |  |
|  |  | **Mobile:** |  |
|  |  |  |  |
| **GP Details** |  |  |  |
| **Name** |  | **Tel No.:** |  |
| **Address:** |  |  |  |
|  |  |  |  |
| **Referral Details** |
| **Name of Referrer:** |  | **Designation:** |  |
| **Tel No.:** |  |  |  |
| **Hospital:** |  | **Ward No.:** |  |
|  |  |  |  |
| **Social History** |
| **Lives With:** | Spouse |  | Partner |  | Alone |  | Family/Friend |  |
| **Lives In:** | Sheltered Accommodation |  | Long Term Care |  |
| **Services prior to admission:** | Yes |  | No |  | **If yes, please provide details:** |
|  |
| **Date of Admission:** |  |
| **Reason for Admission:** |
| **Reason for Referral**: (please state specific Rehab Need) |
| **Relevant Medical History**: (include current diagnosis) |

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| **Activities/Task** | **Previous Level of Function** | **Current level of function** |
| **Communication**:Speech/Language difficulties Speech & Language Therapist’s Name and Contact Number. |  |  |
| **Mobility**Indoors/outdoors, stairs, transfers,Walking aids, etc.Physiotherapist’s Name and Contact Number. |  |  |
| **ADLs**Toileting, personal care, dressing, kitchen, etc.Occupational Therapist’s Name Contact Number |  |  |
| **Nutrition/Swallowing** |  |  |
| **Medication Management**Level, blister pack, etc. |  |  |
| **Care Support**Long term or family support in situ |  |  |

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| **Please provide any other relevant information:** |

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| **Name of Community Staff Member:** |  |
| **Contact Number:** |  |

|  |  |
| --- | --- |
| **Signature of Referrer:** |  |
| **Date** |  |