**Intermediate Care Referral**

**[Clashieknowe]**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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) | | | | | | | | | | | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **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 |  |  |

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

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

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