

****

**PHYSIOTHERAPY REFERRAL FOR CARE HOMES/NURSING HOMES**

Office Telephone: 0131 312 2160

Please send completed referrals to us via:

* Email: ecps.physioathome@nhslothian.scot.nhs.uk
* Post: Physio @ Home, Allermuir Health Centre, 165 Colinton Mains Drive, EH13 9AF

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name** |  | | **CHI/DOB** |  |
| **Care Home Address** |  | | **Unit** |  |
|  |  | | **Tel no** |  |
|  |  | | **Post Code** |  |
| **GP Name** |  | | **GP Address** |  |
| **Next of Kin** |  | **NOK Contact No.** | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DOA TO CARE HOME/NURSING HOME** | | | | |  |
| **New Resident?** | | Yes / No | | | |
| **Previous Medical History:** | | | | **Drug History:** | |
|  | | | |  | |
| **PRESENT LEVEL OF FUNCTION** | | | | | |
| **Transfers** |  | | | | |
| **Mobility** |  | | | | |
| **Normal Walking Aid (if applicable)** | | |  | | |
| **Weight (if known)** | | |  | | |
| **Specific reason for referral** – (please give details, incomplete referrals will be returned): | | | | | |
|  | | | | | |

**Please tick all below that apply:**

|  |  |  |
| --- | --- | --- |
| A. Walking aid assessment |  |  |
| B. History of falls |  |  |
| 1. Positioning / Postural management assessment |  |  |
| 1. Chest management / infection |  | *The resident’s GP is required to make the referral to Physiotherapy* |
| 1. Physiotherapy assessment (Fracture, Pain, Stroke, other) |  |  |
| 1. Manual Handling Concern |  |  |
| 1. Wheelchair provision*: \*Standard wheelchair provision is by*   *Care Home\** |  |  |

|  |  |
| --- | --- |
| **Referrer:** | **Designation:** |
| **Date:** | **Contact no:** |

**Good Practice Checklist**

Not all patients may benefit from physiotherapy, so we would appreciate if you could consider all items on the checklist below prior to making a referral:

|  |  |  |
| --- | --- | --- |
|  | ***X or tick*** | **Comments** |
| ***Pain*** |  |  |
| Is the resident taking painkillers? |  |  |
| Has the resident’s GP been informed? |  |  |
| ***Mobility*** |  |  |
| Has the resident had Physiotherapy before? |  |  |
| Did the resident benefit from Physiotherapy? |  |  |
| Does the resident have the correct walking aid? |  |  |
| Are the walking aid/ferrules in good condition? |  |  |
| Does the resident receive adequate prompts to use their walking aid? |  |  |
| Do carers encourage the resident to mobilise within the home? (with supervision if required) |  |  |
| ***Falls prevention*** |  |  |
| Has the Falls Multifactorial Risk Assessment been completed? |  |  |
| Have all recommendations been put into action? |  |  |
| ***Cognition and communication*** |  |  |
| Can the resident remember information to follow an exercise programme? |  |  |
| Is there a family member/carer that could encourage resident to do exercises? |  |  |
| Does the resident and next-of-kin consent to Physiotherapy? |  |  |
| ***Other healthcare involvement*** | | |
| Are there any other health professionals involved with this resident? |  |  |

|  |
| --- |
| If the resident has a walking aid which is broken/faulty which was provided by **ATEC 24 within the past 18 months,** please contact them directly on **0131 529 6300** to arrange a replacement. |

**PLEASE NOTE: INCOMPLETE REFERRALS TO WILL BE RETURNED TO CARE HOME**