QEF Care and Rehabilitation Centre
Woodlands Road
Leatherhead
Surrey KT22 OBN
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QEF REFERRAL FORM	
Client name:	[Title]
Date of birth:	
NHS no:	
Address:	
Home tel no:	
Mobile no:	
Email:	
Present address if different from above or Hospital and ward	
GP Surgery/Doctor:	
Nationality:	
Ethnic origin:	
Prior to injury, able to communicate in English?	
Is an interpreter required?	
Family/friends network and current housing: Previous employment/ hobbies:	
Next of kin name / relation:	
NOK Contact number:	

MEDICAL AND NURSING	
Diagnosis, acute presentation	Details:
Date of onset	
Past medical history:	
History of diabetes?	Yes/No Details:
Shunt in situ?	Yes/No
History of seizures?	Yes/No Details:
Investigation, consultations pending	
Radiology	Details:
Laboratory	Details:
Referrals	Details:
Current Medications	Details:
Specialist Nursing skills required	
Syringe drivers?	Yes/No
Venepuncture?	Yes/No
IV?	Yes/No
Tracheostomy care?	Yes/No
Nasogastric insertion and/or suction?	Yes/No
Other?	
Allergies/sensitivities	
Drug?	
Food?	
Airborne?	
Hearing	
Hearing aid?	Yes/No
Vision	
Glasses or contact lenses worn?	Yes/No
Visual field deficits?	Yes/No

Fatigue Able to participate in therapy sessions? Rest periods required?	 Yes/No Details: Yes/No Details:
Current skin integrity	
Any pressure areas or skin breakdown (location)?	Yes/No Details:
Pressure-relieving equipment (e.g. airflow mattress or custom seating)?	Yes/No Details:
Able to sit out? For how long every day?	Yes/No Details:
Sleep patterns /assistance required at night?	Details:
Bed rails required?	Yes/No
Standard or specialised bed required e.g. bed length/width/bariatric	
Is 1:1 required?	
Why? How much?	Yes/No *(NB. we are not an open ward with line-of-sight monitoring)*
What 1:1 support are they currently receiving?	
MOBILITY	
History of falls?	Yes/No If yes details:
Transfers – assistance or equipment required?	
Lying to sitting?	
Sit to stand?	
Rolling?	
Toileting?	
Bath/shower?	
Manual/powered wheelchair required?	Yes/No If yes – model/type:
If none, has a referral been made? To which supplier/ funder?	
Name/type of wheelchair cushion prescribed:	

SELF CARE – CURRENT FUNCTIONING	
Washing and dressing	
Support needed?	Yes/No Number of carers required?
Strip wash?	Yes/No
Shower?	Yes/No
Dressing?	Yes/No
Time required?	
Continent of bladder/bowels?	Yes/No
Catheter in situ?	Yes/No
If not, how is continence managed?	
SWALLOWING AND COMMUNICATION	
Swallowing problem?	Yes/No
Has swallowing been assessed?	Yes/No
Current recommendations for fluids and food, including strategies (e.g. needs food cut up)	
Communication	Details:
Expression (able to convey message)	
Level of understanding	
Speech difficulties, voice changes	
AAC (communication aids) used	
COGNITION AND PERCEPTION	
Evidence of acute amnesia/PTA	Yes/No
Difficulties with attention/concentration?	Yes/No
Orientated to time?	Yes/No
Orientated to person?	Yes/No
Orientated to place?	Yes/No
Any impulsivity observed?	Yes/No
Any memory difficulties?	Yes/No Details of any cog assessments conducted:
BEHAVIOUR & MOOD	
Current/history of depression?	Yes/No Details:
Suicidal ideation or deliberate self-harm?	Yes/No Details:

Any other mental health issues?	Yes/No
If so is there a current risk assessment?	Yes/No *(Please attach if so)*
History of abusive behaviour?	Yes/No Details:
Incidents of verbal/physical aggression to people/objects?	Yes/No Details: *(Please attach any behaviour logs/ABCs)*
History of absconding?	Yes/No Details:
MENTAL CAPACITY	
Does client have capacity to consent to this referral/their discharge plan?	Yes/No *(Please add details of BI decision if 'no')*
Currently under a DOLS?	Yes/No
Power of Attorney in place?	Yes/No Details:
DISCHARGE DESTINATION	
Has final destination been identified?	Yes/No Details:
Concerns/issues regarding final discharge destination or safeguarding?	Yes/No Details:
Have social services been involved?	Yes/No Details:
Has a case manager been appointed?	Yes/No Details:
ADDITIONAL INFORMATION	

REFERRER'S DETAILS	
Name:	*Contact Tel No:* *Profession:*
Contact Address:	*Email Address:*
How did you hear of the Care and Rehabiliation Centre:	
Referrer's signature:	*Date:*

PLEASE RETURN FORM TO:
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