Community Rehabilitation and Support Team (CR&ST)
Referral Form:

Tel: 021 4923352
Fax: 0214923469

Details of Person Referred			
Name:	M/F	**Medical Card**	*Exp Date:*
Address:		**GP:** **Tel No:**	
		PHN: **Tel No:**	
Tel:		**Contact Person:** **Tel No:**	
D.O.B:			

Presenting Condition & Current Level of Function

Past Medical History

Social Situation

Lives: Alone □ With Family □ Other/ Details:

Other Services Involved: Physio □ Speech & Language □ Dietician □ Social Worker □ Palliative Care □ Home Help □ Daycare □ Respite □

Falls history:

Reason for Referral:

Nursing Needs_____

_____

Physio needs _____

_____

Occupational therapist needs_____

_____

Criteria for patient referral

- Lives within 5 miles of the city,
- Cognition normal (MTS>8/10) (MMSE> 24/30)
- Requires Rehabilitation from two or more Disciplines
- **Ability** for **Willingness** to partake in an active rehabilitation programme
- Community Dwelling person
- Aged 65 years and over
- No major Communication Difficulties
- No Active **Alcohol** Abuse
- Admitted with a **Fall** Related Injury

1. Please contact team by phone to discuss case

2. Send referral by fax or post if accepted for assessment

Land line 0214923352
Mobile 0867871639

Referred (print):	***Date:***
Contact Tel:	***Title/ Service:***