Addressograph

Referral Form for Neuro Rehabilitation Medicine for under 65 year olds

Dr McFarlane

Patient Name (or attach sticker):_____Ward _____

Address_____Eircode_____

DOB:_____MRN:_____Consultant_____

Next of Kin_____

Relationship_____ Tel. No._____

Diagnoses/Procedures:

1._____ Date_____

2. _____ Date_____

3. _____ Date_____

4._____ Date_____

CT Findings_____

_____

MRI/other findings_____

_____

Reason for referral

☐ Inpatient Consultation

☐ Neuro Rehabilitation

Addressograph

Current Impairments: (please circle or tick)

- ☐ Cognitive
- ☐ Communication
- ☐ Hemiparesis ☐ Left Right ☐
- ☐ Paraparesis
- ☐ Tetraparesis ☐ Visual field (☐ Left Right ☐)
- ☐ Sensory ☐ Visuospatial
- ☐ Swallow ☐ Tracheostomy

Other_____

Signed_____ Name_____

Date _____

Position: ☐ Intern ☐ SHO ☐ SpR ☐ Cons ☐ CNS ☐ Physio ☐ OT ☐ SLT