**Warrington Neuroscience’s Team Referral Criteria:**

The Warrington Neurosciences Team offers community services to patients who **live in Warrington** or have a **Warrington GP**, with neurological rehabilitation needs. We can provide input from disciplines including specialist Parkinson’s Disease and Neurological Conditions Nurse, Acquired Brain Injury Occupational Therapist, Physiotherapy, Occupational Therapy and Psychology.

**Age:** 18 years and over. Any referrals for those aged 16–17 with neurological rehabilitation needs should be discussed with the community service prior to submitting the referral form.

**A confirmed Neurological Diagnosis**: **The patient must be aware of and accepting of their medical diagnosis.** Include investigations and imaging detail in the referral.

The service does not offer vestibular rehabilitation and **cannot accept** patients for the management of:

* Congenital/developmental neurological disorder
* Peripheral Neuropathy
* Cerebral Palsy
* Bell’s Palsy
* Spinal Injury/Surgery without neurological deficit
* Progressive degenerative dementing illness
* Transient Ischaemic Attack (TIA)
* Functional Neurological Disorder (FND)
* Epilepsy

**Consent:** The patient must be made aware of the referral to the service. If referral is made in patients’ best interest, please attach relevant documentation.

**Participation:** The patient must be able to participate and or engage with therapy services. **The patient must have clear and achievable rehabilitation goals.**

**Triage:** All referrals are made via the referral form, usually by a registered healthcare professional. Referrals are triaged no less than twice weekly following the triage guidelines; referrer and or patient may be contacted for additional information. During triage referrals will be categorised urgent or routine. **Forms that do not contain sufficient information will be returned to the referrer and the patient will not be accepted to the service.**

**DNA policy**: Patients who do not attend will be manage in accordance with the Trust policy.

***Please note***

* This is not a crisis management community service, and we cannot respond to patients who need an urgent visit on discharge from hospital. Where there are other pre-existing services/pathways available to meet their needs (e.g. Falls, palliative care, community team service, etc) the referrer will be signposted to such services.
* Neuropsychology facilitates patients with psychological difficulties which are a direct consequence of their neurological condition. This is not a mental health service. Where patient’s primary need is related to mental health condition, please contact the service prior to referral to discuss whether the referral to this service is suitable for the patient.

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| **Patient Details** Consented to and aware of referral? Yes / No Mental Capacity issues: | | | | | |
| Address:  Post Code:  Key Safe Yes/No: | Title:  First Name  Surname:  Pronouns: | | Date of Birth:    NHS Number: | | Telephone Number:  Mobile Number:  Email: |
| GP Name**:**  Practice:  Telephone: | Consultant details:  Specialist Nurse details: | | **Next of Kin:**  Relationship:  Address:  Post Code:  Telephone: | | |
| Accommodation type:  (House/Bungalow/Flat/Sheltered living/ RH/NH)  Lives alone Yes/No Details  Formal Care Yes/No Agency Details | Employment status:  Occupation:  Car driver: Yes/No  Current driving status:  Patient caring responsibility or has dependents Yes/No | | | Languages spoken:    Interpreter needed? Yes/No  Communication ability:  Armed Forces: □ | |
| **Lone working risk:** Unknown/ No/ Known **Details**:  **Visit by 2 members of staff** Yes / No | | | | | |
| Pets: | Known substance misuse: | | | | |
| **Can the patient attend clinic** □ **Is the patient (housebound)** □ **Is the patient able to answer the door?** Yes / No | | | | | |
| Cancer diagnosis: □  Past Medical History:  Mental Health Background: | **Other agencies known to be active:**  Social Services □ District Nurse □ Dietitian □ SALT □ Podiatry □ Dietician □ Orthotics Team □ Ophthalmology □ Continence Service □ IMCA □ Other □  Details: | | | | |
| **Neurological Diagnosis:** | | **Reason for referral:** | | | |
| Summary of any recent intervention/functional changes:  Concerns Re: Carer Breakdown: □  Concerns Re: potential hospital admission: □ | | **Disciplines required, (tick all that apply)**  Physiotherapy □ Occupational Therapy □  ABI Occupational Therapy □ Neuro specialist nurse □  Psychology□  Are the patient's psychological difficulties related to their neurological condition? YES / NO.  *If the answer is NO or their anxiety/ low mood/ depression predate their neurological condition, please consider referring to IAPT- Talking Matters. If the patient experiences moderate - severe symptoms of mental illness or conditions like schizophrenia or bipolar disorder, please consider referring to the Mental Health Team.* | | | |
| Equipment in situ or ordered?  Does the patient have a bed lever or cot sides yes/no :  Risk assessment completed yes/no | |
| **Please identify the patient rehabilitation goals:**  **1**  **2**  **3** | | **Specific intervention**  Contracture Management □ / Postural Management □  Spasticity Management □  Functional Electrical Stimulation Assessment □  Vocational Rehabilitation □  Fatigue Management □ Cognitive Skills Group □  Balance Group □ Nordic Walking group □ | | | |
| **Referrer details:**  Name:  Profession:  Address:  Post Code:  Telephone number:  Email address:  SIGNED: Date: | | **Send to:** Email: [bchft.neurowarrington@nhs.net](mailto:bchft.neurowarrington@nhs.net)  By Post:  Warrington Community Neurosciences Team, 2nd Floor Orford Jubilee Hub, Jubilee Way, Orford WA2 8HE  **Please do not email referrals to individual clinicians.** | | | |