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|  | | **Sirona integrated network team community**  **therapy referral form**  **E-mail North Somerset Referrals to:** [Sirch.northsomersetspa@nhs.net](mailto:Sirch.northsomersetspa@nhs.net)  **E-mail Bristol Referrals to:** [Sirch.bristolspa@nhs.net](mailto:Sirch.bristolspa@nhs.net)  **E-mail South Glos Referrals to:** [Sirch.southglosspa@nhs.net](mailto:Sirch.southglosspa@nhs.net) | | |
| Date of Referral: | | Has the patient consented to this Referral? ✓ Yes 🞏 No 🞏 |

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| **Does the patient require an Urgent Therapy Assessment within the next 48 hours to prevent a hospital admission?**   * Yes **– please contact SPA 0300 125 6789 to make an Urgent Referral** * No- please continue to complete this form |
| **Does the patient require Specialist Neuro Therapy or SALT (Speech and Language Therapy) intervention? Follow the links below to locate and complete the appropriate referral form.**   * **Neuro Therapy:**   <https://remedy.bnssg.icb.nhs.uk/adults/neurology/specialist-community-neurology/>   * **SALT Service: *please see specific criteria on remedy to ensure referral is accepted***   + North Somerset SLT referrals: use form under ‘North Somerset section’ <https://remedy.bnssgccg.nhs.uk/adults/speech-language/slt-community-services/>   + Bristol/ South Glos: Is this patient receiving therapy input from a Sirona Integrated Network Team?     - If yes, use form under ‘Bristol’ or ‘South Gloucestershire’ section: https://remedy.bnssg.icb.nhs.uk/adults/speech-language/slt-community-services/     - If no, refer to acute trust community SLT services <https://remedy.bnssgccg.nhs.uk/adults/speech-language/slt-hospital-outpatients/> |
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Patient Information:

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| Patient’s Name: | NHS Number: |
| Patient’s current location/address: | Communication/Cultural needs: |

Referrer/Patient’s GP Information:

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| Referrer’s Information | GP Details |
| Referrer’s Name and Profession:  Contact Telephone Number: | GP Name:  GP Practice: |

Reason for Referral

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| **Type of referral (please tick all which apply):**   * **Rehabilitation- mobility/transfers** * **Falls Assessment/Intervention** * **Equipment Provision** * **Activities of Daily Living Rehabilitation**   **Has the patient been seen by INT Therapy within the last 12 months for the same issue?**   * **Yes- consider appropriateness of referral and what further therapy intervention might add** * **No- please continue to complete this form**   Reason for referral (summary):  **Patient’s expectation/s from Therapy Intervention:** |
| Exclusions and signposting  We are unable to accept referrals for the following:   * **Outdoor mobility issues without health need**   + Signpost to Voluntary Sector e.g. Age UK, Red Cross, Social Prescribing.   + For equipment signpost to Mobility Shops, Red Cross. * **Wheelchair provision**   + For indoor wheelchair assessment signpost to Centre for Enablement.   + For outdoor, non-specialist/attendant propelled signpost to Mobility Shops/Red Cross. * **Major adaptations e.g wetroom, extensions, ramps outside for wheelchair access, through floor lifts, ceiling track hoists**   + Signpost to Local Authority OT * **Review of manual handling where no acute deterioration or identified health need**   + Signpost to:     - Patients in care home - signpost to manual handling advisor in care home     - Broken/damaged equipment – signpost to Medequip     - Patient has existing care package – signpost to provider for manual handling risk assessment * **Bathing assessments/equipment where no acute deterioration or identified health need**   + Signpost to Local Authority OT * **Orthotics/splinting**   + Refer to NBT/UHBW orthotics * **Patient under the care of AWP (Avon Wiltshire Partnership)**    + Refer to AWP |

*Thank you for your referral. Once received, the referral will be screened to ensure it is appropriate for INT Therapy Services. It will then be passed to the relevant INT for ongoing management. If the patient’s needs are deemed to be non-urgent they will remain on a waiting list until they can be managed.*