Patient ID

The Royal Liverpool and Broadgreen University Hospitals NHS Trust **NHS**

THERAPIES DEPARTMENT (PHYSIO)

REASON FOR PHYSIO REFERRAL	PATIENT'S PERCEPTION OF NEED/ GOALS

CONSENT	SUBJECTIVE HISTORY
Has the purpose of the physiotherapy assessment been explained? ☐ Yes ☐ No Comments: How was the consent obtained? ☐ Verbal ☐ Implied ☐ from NOK/ Proxy (as per MCA)	Subjective history obtained from: Patient ☐ NOK ☐ Other …………………………………………………… Consent gained to contact 3rd party from patient if required ☐

HISTORY

PC	HPC
PMH	**Additional information:**

HOME SITUATION			
Accommodation	**Lives with**	**Stairs**	**Access**
☐House ☐Sheltered______floor ☐ Flat___________ floor ☐Bungalow ☐ Other ________________ Owned by:__________ __________________	☐ Alone ☐ Lives with __________________ __________________ ☐ Cares for __________________ __________________	☐ None ☐ Downstairs living ☐ Stair-lift / through floor lift ☐ 2 Banisters ☐ Left rail ↑ ☐ Right rail ↑	Front______________ __________________ Back______________ __________________ Internal____________ __________________

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THERAPIES DEPARTMENT (PHYSIO)
Usual daily activity
Formal care:

Visits per day ______________ Number of carers __________ Day Centre ________________ ____________________________	☐ Personal care ☐ Meal Preparation ☐ Back to bed service ☐ Night call ☐ Other_____________________	☐ Lifeline ☐Keysafe ☐ Warden ☐ Pull cords ☐Telephone ☐ Other ____________________

Other support / agencies involved	**Family/ informal support**

VISION, HEARING AND COMMUNICATION			
	VISION	**HEARING**	**COMMUNICATION**
Impaired? Y/N? If Yes Specify			
Aids used (specify)			
Comments			

MENTAL HEALTH	
PREVIOUS history **Any mental health or cognitive issues already known about patient**	**CURRENT status** **Orientation, cognition, mood, motivation**

Is patient known to Mental Health Services?	**YES** □	**NO** □	**DON'T KNOW** □

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THERAPIES DEPARTMENT (PHYSIO)	
OBJECTIVE ASSESSMENT	
UPPER LIMB Function: (e.g. ROM, strength, sensation)	
LEFT ☐ Dominant hand	**RIGHT** ☐ Dominant hand
LOWER LIMB Function: (e.g. ROM, strength, sensation)	
LEFT	**RIGHT**
TRUNK AND POSTURE	

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FALLS

Is there a history of falls in the last 12 months?	Describe mechanism of fall(s):
☐ Yes Number:______________ ☐ No ☐ Unknown State reason ___________ _____________________________________	
☐ YES	
Other assessments:	

Sitting:	☐ dynamic unsupported ☐ unsupported ☐ self-supported	☐ supported only/ unsafe
Standing:	☐ unsupported ☐ able to reach >25cms	Assistance of : ☐ 1 ☐ 2 ☐ Unable ☐ walking aid ________________
Standard TUSS	☐> 1 minute	☐< 1 minute
180 degree turn	☐ ≤ 5 steps	☐ ≥ 6 steps No. ________
Rhomberg Test	☐ Negative	☐ Positive
HIGHFALLS RISK Identified	☐ NO	

FUNCTION :		
TRANSFERS	**ABILITY**	
	USUAL	**CURRENT**
BED MOBILITY		
CHAIR (INC. SIT TO STAND, HEIGHT)		
TOILET		

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EQUIPMENT		

INDOOR MOBILITY:

	USUAL	**CURRENT**
GAIT	☐ Independent, no aids ☐ Independent, with aids ☐ Assisted with 1 ☐ Assisted with 1 + aid ☐ Assisted with 2 ☐ Assisted with 2 + aid Aids used, specify: ______________________ Other remarks (e.g. use of orthoses):	☐ Independent, no aids ☐ Independent, with aids ☐ Assisted with 1 ☐ Assisted with 1 + aid ☐ Assisted with 2 ☐ Assisted with 2 + aid Aids used, specify: ______________________ Other remarks:

ADDITIONAL GAIT ASSESSMENT:

OUTDOOR MOBILITY:

☐ Independent, no aids ☐ Independent, with aids ☐ Assisted with 1 ☐ Assisted with 1 + aid ☐ Assisted with 2 ☐ Assisted with 2 + aid Aids used, specify: ______________________ ☐ Wheelchair ☐Not mobile Exercise tolerance ______________	Other comments (driving/ travel by public transport etc.)

STAIRS:

Is a stair assessment indicated ☐ YES ☐ NO ☐ Unknown on initial assessment

Comments:

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ADDITIONAL INFORMATION

ANALYSIS OF THERAPY FINDINGS (PHYSIO)

THERAPY PLAN (inc. equipment supply)

EQUIPMENT ORDERED/ ISSUED? (CIRCLE)

DATE OF ORDER:

ORDER NUMBER:

AGREED OUTCOME (S)

Signature	Name	Designation	Date & time