MAJOR TRAUMA – REHABILITATION PRESCRIPTION

NHS
Northern Trauma Network

Core Information

Date Commenced:	Time Commenced:	Commenced By:
GP:	Date of Injury:	
Insert label or: Surname: First Name: Date of Birth: Address: NHS no:	MTC: Current Location: Key Worker/Lead professional:	

The TARN minimum dataset (this section MUST be completed)			
Rehabilitation prescription (completed or not required)	☐ No	☐ Yes	☐ Not required
Presence of physical factors affecting activities or participation	☐ No	☐ Yes	☐ Not assessed
Presence of cognitive/mood factors affecting activities or participation	☐ No	☐ Yes	☐ Not assessed
Presence of psychosocial factors affecting activities or participation	☐ No	☐ Yes	☐ Not assessed

Initial GCS:

Clinical History and List of all Injuries:

Type(s) of injury

❒ Neurological:	❒ Musculoskeletal	❒ Vascular	❒ Other……
❒ Brain Injury	❒ Burns	❒ Abdominal	
❒ SCI	❒ Thoracic	❒ Amputation	Initial lead specialty:

Summary of Interventions to date:

Progress, Management and Complications:

Pre-injury / Illness Information *(including social situation, housing, vocation / roles, leisure)*

Name:	Designation:	Signed:	Date:

Prescription Review Status:

☐ Initial ☐ Core or ☐ Supplementary Prescription	☐ Review _____ of _____	Planned Date of Next Review:

Insert Patient ID Label

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Summary

Rehabilitation Goals *(including predicted time frame)*

Key Management Plan: *(e.g. procedures / reviews awaited, advice re: weight bearing status, use of orthoses)*

Services Referred to: *(including contact details and anticipated waiting time)*

Therapies involved/needed

Acute Pain Team		Dietitian		Psychiatry		Tissue Viability		Head Injury Nurse	
Physiotherapy		OT		Social Services		Orthotics		Teaching/Play	
Speech & Language		Health Psychology		Neuro Psychology		Ophthalmology		Other	

Other Key Information: *(e.g. patient/family wishes, potential discharge barriers, immigration/residency)*

Rehabilitation Complexity Scale Extended (RCS-E) Trauma version

	0	1	2	3	4	5	6
Medical	None active	Basic	Specialist	Potentially unstable	Acute medical/surgical	TU	MTC
Care	Independent	1 carer	2 carers	≥ 3 carers	1:1 supervision		
Risk	None	Low	Medium	High	Very high		
Nursing	None	Qualified	Rehab nurse	Specialist nursing	High dependency		
Therapy disciplines	None	1	2-3	4-5	≥ 6		
Therapy Intensity (Total therapist time)	None	low level (< daily) <15 hrs/wk	Moderate (eg daily) 15-24 hrs/wk	High (+ assistant) 25-30 hrs/wk	Very high >30 hrs/wk		
Equipment	None	Basic	Specialist	Specialist - trauma	-		

RCSE: M_____ C / R (whichever highest)__________ N_________ Td__________ Ti__________ E__________Total___/25

Rehabilitation Services Required:

Level 1 □ Level 2a □ Level 2b □ Level 3 □

CRM Involvement: Yes □ No □
Describe: ……………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
Signed: Date:

Name: Designation: Signed: Date:

Patient / carer has received copy of Rehabilitation Prescription? Yes □ No □

If not shared with patient/carer, reason withheld: ……………………………………………………………………

This rehabilitation prescription is prepared on the basis of assessments made to date and is subject to modification following further assessment by future service providers however it provides no guarantee of service availability.

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Supplementary Data

Functional Status and Intervention Required:

	Tick all that apply	**Details and Plan**
Neurological/ Locomotor	☐ GCS: E____V_____M_____ Total_______ ☐ Motor loss ☐ Sensory loss/hypersensitivity ☐ Visual impairment ☐ Hearing impairment ☐ Increased tone ☐ Decreased tone ☐ Contracture ☐ Pain ☐ Other musculoskeletal problem ☐ Splinting/orthotics required	
Respiratory	☐ Self ventilating ☐ Assisted ventilation: type? ______________ ☐ Tracheostomy ☐ ET tube ☐ Oxygen therapy ☐ Weaning plan/management plan ☐ Chest physiotherapy/suction	
Mobility & Transfers	☐ Nursed in bed ☐ Independent sitting balance ☐ Wheelchair/special seating ☐ Walks independently ☐ Unable to walk ☐ Walks with help of ___________persons ☐ Walks with supervision only ☐ Walks with an aid __________________ ☐ Transfers independently ☐ Transfers with help of _______persons ☐ Transfers with an aid _______________	
Continence	☐ Continent – independent ☐ Continent – assistance of ____persons ☐ Urinary incontinence ☐ Catheter/pads/conveen ☐ Urine retention ☐ Faecal incontinence ☐ Constipation ☐ Bowel regime	
Skin	☐ *Pressure sore* risk score ______________ (type of scoring used _________________) ☐ Pressure sore/s identified ☐ Other wounds	

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Functional Status and Intervention Continued:

	Tick all that apply	**Details and Plan**
Communication	☐ Not impaired ☐ Impaired ☐ Expressive dysphasia ☐ Receptive dysphasia ☐ Communication aids used ☐ Type of aid ________________________ ☐ SLT required ☐ Dysarthria ☐ Other communication deficits	
Nutrition & Hydration Status	☐ Swallowing not impaired ☐ Swallowing impaired ☐ Nil by mouth ☐ Modified diet – type _____________ ☐ Modified fluids – type ___________ ☐ Independent with/without aids ☐ Requires prompting/supervision only ☐ Requires assistance of_____persons ☐ Fed via NGT/PEG/PEJ/TPN ☐ Dietitian required ☐ SLT required	
Washing & Dressing	☐ Independent ☐ Requires prompts/supervision only ☐ Requires assistance of _____persons ☐ Unable to participate in any way	
Cognitive / Psychosocial	☐ Sensory (vision/hearing) ☐ Cognitive/perceptual ☐ Behavioural management ☐ Mood/emotional management ☐ Safety awareness management ☐ Requires close supervision ☐ Requires 1:1 supervision ☐ Formal family support ☐ Psychology required ☐ Psychiatry required ☐ Consent or Capacity considerations	
Discharge Planning	☐ Housing/placement ☐ Environmental/home visit ☐ Equipment/home adaptations ☐ Community support ☐ Vocational/educational services ☐ Benefits/finances ☐ Social Services required	
Name: Designation:	Signed:	Date:

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Appendix 1

Injury Management - Detailed Information

Injury	Consultant/Team	Management Plan	Review Date	Actions Required

Appendix 2

Additional information/comments