# MAJOR TRAUMA – REHABILITATION PRESCRIPTION
## Core Information

| | | | | |
|---|---|---|---|---|
| **Date Commenced:** | **Time Commenced:** | | **Commenced By:** | |
| **NHS no:** | | **Date of Injury:** | | |
| **Insert label or:**<br>Surname:<br>First name:<br>Date of birth:<br>Address:<br><br>GP: | | **Current location:**<br><br><br><br>**MTC:** | | |
| **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 required** |
| Presence of cognitive/mood factors affecting activities or participation | | **□ No** | **□ Yes** | **□ Not required** |
| Presence of psychosocial factors affecting activities or participation | | **□ No** | **□ Yes** | **□ Not required** |
| **Initial GCS:**<br>**List of all injuries:** | | | | |
| **Summary of Interventions to date**: | | | | |
| **Progress, management and complications:** | | | | |
| **Pre-injury/illness information** | | | | |
| Significant medical history | | | | |
| Family support | | Work | | |
| Housing | | Leisure | | |
| Name:<br><br>Designation: | Signed: | | Date: | |

Insert patient ID or label

## 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)*

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

**Complexity: Rehabilitation Complexity Scale Extended (RCS-E)** (Refer to UKROC guidance for scoring)

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **Care** | Independent | 1 carer | 2 carers | ≥ 3 carers | 1:1 |
| **Risk** | None | Low | Medium | High | Very high |
| **Nursing** | None | Qualified | Rehab nurse | Specialist nursing | High dependency |
| **Medical** | Non active | Basic | Specialist | Potentially unstable | Acute medical/surgical |
| **Therapy disciplines** | None | 1 | 2-3 | 4-5 | ≥ 6 |
| **Therapy intensity** | None | Low level (< daily) | Moderate (eg daily) | High (+ assistant) | Very high (>30 hours/week) |
| **Equipment** | None | Basic | Specialist | - | - |

**RSCE: C _____ N_____ M_____ Td_____ Ti_____ E_____ Total_____/22**

| | | |
|---|---|---|
| Name: | Signed: | Date: |
| Designation: | | |

Insert patient ID or label

## Supplementary Data

**Functional Status and Intervention Required:**

| | Tick all that apply | Details and Plan |
|---|---|---|
| Neurological/ Locomotor | ◘ GCS: E____ V____ M____ Total _____<br>◘ Motor loss<br>◘ Sensory loss/hypersensitivity<br>□ Visual impairment<br>□ Hearing impairment<br>□ Increased tone<br>□ Decreased tone<br>□ Contracture<br>□ Pain<br>□ Other musculoskeletal problem<br>□ Splinting/orthotics required | |
| Respiratory | □ Self ventilating<br>□ Assisted ventilation: type? _____<br>□ Tracheostomy<br>□ ET tube<br>□ Oxygen therapy<br>□ Weaning plan/management plan<br>□ Chest physiotherapy/suction | |
| Mobility & Transfers | ◘ Nursed in bed<br>◘ Independent sitting balance<br>◘ Wheelchair/special seating<br>□ Walks independently<br>□ Unable to walk<br>□ Walks with help of _____ persons<br>□ Walks with supervision only<br>□ Walks with an aid _____<br>□ Transfers independently<br>□ Transfers with help of _____ persons<br>□ Transfers with an aid _____ | |
| Continence | □ Continent – independent<br>□ Continent – assistance of ____ persons<br>□ Urinary incontinence<br>□ Catheter/pads/conveen<br>□ Urine retention<br>□ Faecal incontinence<br>□ Constipation<br>□ Bowel regime | |
| Skin | □ Pressure sore risk score _____<br>(type of scoring used _____)<br>□ Pressure sore/s identified<br>□ Grade _____ location _____<br>□ Grade _____ location _____<br>□ Grade _____ location _____<br>□ Other wounds<br>□ Treatment plan documented<br>□ Tissue viability nurse required<br>□ Special mattress/cushion | |
| Name: Signed: Date:<br><br>Designation: | | |

Insert patient ID or label

**Functional Status and Intervention Continued:**

| | | |
|---|---|---|
| Communication | □ Not impaired<br>□ Impaired<br>□ Expressive dysphasia<br>□ Receptive dysphasia<br>□ Communication aids used<br>□ Type of aid _____<br>□ SLT required<br>□ Dysarthria<br>□ Other communication deficits | |
| Nutrition & Hydration Status | □ Swallowing not impaired<br>□ Swallowing impaired<br>□ Nil by mouth<br>□ Modified diet – type _____<br>□ Modified fluids – type _____<br>□ Independent with/without aids<br>□ Requires prompting/supervision only<br>□ Requires assistance of_____ persons<br>□ Fed via NGT/PEG/PEJ/TPN<br>□ Dietitian required<br>□ SLT required | |
| Washing & Dressing | □ Independent<br>□ Grooms self<br>□ Requires prompts/supervision only<br>□ Requires assistance of _____persons<br>□ Unable to participate in any way | |
| Cognitive/ Psychosocial | □ Sensory (vision/hearing)<br>□ Cognitive/perceptual<br>□ Behavioural management<br>□ Mood/emotional management<br>□ Safety awareness management<br>□ Requires close supervision<br>□ Requires 1:1 supervision<br>□ Formal family support<br>□ Psychology required<br>□ Psychiatry required | |
| Discharge Planning | □ Housing/placement<br>□ Environmental/home visit<br>□ Equipment/home adaptations<br>□ Community support<br>□ Vocational/educational services<br>□ Benefits/finances<br>□ Social Services required | |
| Name: | Signed: | Date:<br><br>Designation: |

**Sign-off by Consultant in Rehabilitation Medicine:_____**

Name: Signed: Date: