

Department:	Rehabilitation Centre		
Document:	Multidisciplinary Policy and Procedure		
Title:	Inpatient Referral		
Applies To:	Rehabilitation Staff, Physicians & Nurses		
Preparation Date:	January 11, 2024	Index No:	REH-MPP-002
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1. PURPOSE:

- 1.1 To provide an effective healthcare, and to ease the procedures of initiating treatment strategy for those patients admitted in the hospital, who require rehabilitation services, when referred by the most responsible physician (MRP).

2. DEFINITIONS:

- 2.1 MRP: Most Responsible Physician.
- 2.2 PICU: Pediatric Intensive Care Unit.
- 2.3 P. Wards: Pediatric wards.
- 2.4 NICU: Neonatal Intensive Care Unit.

3. POLICY:

- 3.1 Any patient needs a rehabilitation service has to be referred by most responsible physician (MRP).
- 3.2 Service cannot be provided without a valid referral involving complete information.
- 3.3 Patient should be evaluated and treated within 24 working hours after receiving the referral from the wards.

4. PROCEDURE:

- 4.1 When the MRP decides that an in-patient needs rehabilitation services, he / she must send the patient's referral form to rehabilitation centre.
- 4.2 The physician has to complete the referral form with all relevant information, and then hand over to the nurse in charge of the ward who will be responsible for verify that all referral information is complete and submitting it to rehabilitation centre in time.
- 4.3 If any of referral information is incomplete, the referral will be returned to the ward in order to complete the referral information.
- 4.4 The therapist has to evaluate and treat the patient within 24 working hours of receiving the referral form.
- 4.5 The therapist has to review the patient medical file and consider the precaution if present.
- 4.6 After performing the assessment, the goals and treatment plan should be documented.
- 4.7 The therapist has to follow up the patient regularly, note down the findings and procedures done during every visit in the progress note sheet until the patient discharge. The progress note should be duly signed with date and time by the responsible therapist during each visit.
- 4.8 The patient can discharge/remove from Rehabilitation services for the following reasons:
 - 4.8.1 Discharged from the hospital.
 - 4.8.2 Discharged by the Physicians (order to discontinuing the physiotherapy sessions)
 - 4.8.3 Transfer to another hospital.
 - 4.8.4 Goals have been achieved.
 - 4.8.5 Patient died.
- 4.9 If the patient transfers from one ward to another, a new referral has to be provided.

4.10 Any patient those requiring continued rehabilitation program after discharge from the hospital inpatient wards, a new referral form has to be submitted to Rehabilitation department.

5. MATERIALS AND EQUIPMENT:

- 5.1 Rehabilitation assessment form.
- 5.2 Follow up form.
- 5.3 Discharge form.
- 5.4 Education form

6. RESPONSIBILITIES:

- 6.1 All staff in Rehabilitation department.
- 6.2 All Nurses
- 6.3 All physicians.

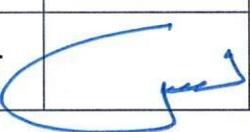
7. APPENDICES:

- 7.1 Rehabilitation Services Referral Form.
- 7.2 Consultation form.

8. REFERENCES:

- 8.1 Polices & procedures of rehabilitation centre in KKGH-Hail.
- 8.2 Polices & procedures of rehabilitation centre in KKGH- Hafer-Albatin.
- 8.3 Polices & procedures of Physiotherapy Department MCH- Al-jouf.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms .Amira Yahya Hamed	Head of Rehabilitation Centre		January 11, 2024
Reviewed by:	Mr. Sabah Al.Harby	Nursing Director		January 18, 2024
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 18, 2024
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 18, 2024
Approved by:	Mr. Fahad Hazam Alshammari	Hospital Director		January 25, 2024

Appendix 7.1

Kingdom of Saudi Arabia
Hafer Al Batin Health Cluster
Maternity and Children Hospital



المملكة العربية السعودية
الجمع الصحي بحفر الباطن
مستشفى الولادة والأطفال

REHABILITATION SERVICES REFERRAL FORM

NAME: _____
MEDICAL RECORD NUMBER: _____ NATIONALITY: _____
ROOM NO: _____ BED NO: _____ AGE: _____
DATE & TIME OF ADMISSION: _____
DATE OF BIRTH: _____
GENDER: MALE FEMALE

All information within the referral has to be completed. Incomplete referral form will be returned to the referred physician.

Physical Therapy Occupational Therapy Speech therapy
 Physical Medicine and Rehabilitation (only intradepartmental referring)
 Out Patient Inpatient: (Ward: _____ Room: _____)

Clinical Features:

Radiology Results:

Diagnosis:

Reason (s) for Request:

Relieve Pain	Increase Function	Cognitive Training
Increase ROM	Ambulate:	Activities of Daily Living Training
Increase Muscle Strength	O FWB O PWB O NWB	Hand Functional Training
Reduce Swelling	Others: _____	

Comorbid Conditions:

Hypertension	Deep venous thrombosis	Osteoporosis
Diabetic mellitus	Pregnancy	Cancer
Cardiac problems	Infectious diseases	Others: _____

Precautions: No Yes: _____

Consultant / Specialist Name: _____ Referring Date: _____

Signature: _____



CONSULTATION FORM

NAME: _____

MEDICAL RECORD NUMBER : _____ **NATIONALITY:** _____

ROOM NO: _____ BED NO: _____ AGE: _____

DATE & TIME OF ADMISSION: _____

GENDER: MALE FEMALE

To Dr. _____ Designation and Specialty: _____

Date of Admission: URGENT NOT URGENT

Provisional Diagnosis/Problems:

1. Professional Diagnosis/Problems: _____ Physician: _____ Signature: _____ Date: _____

Bleep/ Mobile Number: _____ Time: _____

OBJECT OF CONSULTATION AND CLINICAL NOTES (INCLUDING INVESTIGATIONS AND FINDINGS)

CONSULTANT'S REPORT

FINDINGS:

RECOMMENDATIONS:

CONSULTANT:

SIGNATURE:

DATE:

TIME:



CONSULTATION FORM

NAME: _____

MEDICAL RECORD NUMBER :

NATIONALITY:

ROOM NO:

DATE & TIME OF ADMISSION:

DATE OF BIRTH:

GENDER: MALE FEMALE

CONSULTATION (CONTINUATION)