

Adult Burns Rehabilitation Prescription

Insert Patient ID or label

Core Information

GP:		Date of Injury:
Burn Service:	Current Location:	Key Worker/Lead Professional:
Clinical History:		
Medications:		
Summary of Interventions to date:		
Progress, Management and Complications:		
Pre-Injury / Illness information (including social situation, housing, vocation, roles and leisure:		

Summary

Rehabilitation Goals (including predicted time frame)

Key Management plan: (e.g. procedures/reviews awaited, advice re scarring, use of orthoses etc)

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

Therapies involved/needed

Acute Pain Team		Chronic Pain Team		Psychiatry		Orthotics	
Physiotherapy		OT		Social Service		Psychology	
Speech & Language		Ophthalmology		Dietitian		Other	

Referrals required by G.P.:

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



Name:	Designation:	Signed:	Date: