Community Stroke Team Patient Referral Form

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| **Community Stroke Team Admin Use Only:** | | Date Email Received: |  |
| Date Referral Reviewed by CST: |  | Referral Reviewed by: |  |
| Accepted by CST: | Yes / No | Date of Initial Assessment: |  |
| Initial Assessment Therapist: |  | Time of Initial Assessment: |  |
| Date Patient Informed of Initial Ax: |  | Patient informed by: |  |

**Please complete the following information and email to the Community Stroke Team** **ngh-tr.cst@nhs.net**

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| Hospital No: |  | | NHS No: | |  |
| Patient Name: |  | | Date of Birth: | |  |
| Patient Home Address: |  | Address on Discharge (if different): | |  | |
| Patient Telephone No: |  | Alternative Contact:  Tel No: | |  | |
| Patient spoken language: |  |
| Key Safe Number: |  |
| Ethnicity/Cultural needs: |  | Covid Status: | |  | |
| Any risks identified for lone workers? | No/Yes. If yes details: | | | | |
| Communication difficulties? |  | Hard of Hearing? | |  | |
| Visual deficits? | |  | |
| Food/ Fluid levels: |  | GP Name | |  | |
| Consultant: |  | GP Surgery Address  Post Code  Telephone Number | |  | |
| DNAR status: |  |
| Type of Stroke:  Date of Stroke: |  |
| Ward/Hospital: |  | Discharge Date: | |  | |
| Relevant Medical History  *(Physical health, mental health, health impacting limitations e.g.: lower limb OA)* |  | | | | |

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| **Discharge & Care Plan** | | | | | | | | |
| Care Package in Place? | Yes/No | | | Number of care calls per day: | | |  | |
| Discharge to assess | Yes/No | | | Number of carers per care call: | | |  | |
| Name of care provider & contact details: |  | | | Carers Duties:  *(Personal care, meals, medication management, wash & dress etc)* | |  | | |
| Total daily care minutes provided: |  | | Number of days per week: | |  | Date & Time of First Care Call: | |  |
| Reason for change in discharge destination & plans for returning home: | |  | | | | | | |
| Long Term Care Plan:*(Length of care input or planned reduction in care)* | |  | | | | | | |
| Family Support for ongoing care/rehab & Timescale: | |  | | | | | | |

**Additional information:**

**Reablement information (only if CST-Reablement referral is included):**

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| Reason reablement required: | | | | |
| Reablement calls requested: | Morning  Yes/No | Lunch  Yes/No | Tea-time  Yes/No | Evening  Yes/No |
| Statistics: | Waterflow: | Height: | Weight: | DNAR Status: |

**For All Patients:**

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| Equipment & Orthotics | Equipment Provided:  *(Commode, perching stool, mobility aids, ramps etc)* |  |
| Prescriber name and date delivered: |  |
| Orthotics Referral Completed/Referring therapist: | Yes/No  Name: |
| Date referral sent: |  |
| Orthotics provided: *(AFO, shoulder cuff, WHO, Boxia etc)* |  |
| Orthotics regime:  *(Is a plan in place, handed over to carers/family?)* |  |

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| Capacity Ax / Concerns around capacity: | |  | |
| Initial Stroke Presentation/ symptoms: | |  | |
| Driving | Yes/No | Driving Leaflet given to patient: Any comments? | Yes/No |
| Pre-Stroke Hobbies/ Work/ Family/ Friends/ relationships/ Animals/ interests/ usual routine/baseline | |  | |

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| **Stroke Rehab So Far:** | | | | | |
| **Physio:**  *(Strength/ sensation/ proprioception’s/ co-ordination etc/ mobility/ transfers/ ongoing therapy)* |  | | | | |
| **Spasticity Management:** *(medication/ stretches shown/ botox clinic/ date)* |  | | | | |
| **OT:**  *(Functional tasks- W&D, Kitchen, Cognition, home visit completed)* |  | | | | |
| **SALT:**  *(Communication difficulties, swallow, diet, fluid/meals)* |  | | | | |
| **Nurse**    *Overnight & day needs/ sleep/ fatigue/ mood concerns* |  | | | | |
| **Medication Management:**  *(Self-managing/ family input/ medication changes/ reasons for change)* |  | | | | |
| **Continence:**  *(Ongoing management plans, referral to continence nurse?)* |  | | | | |
| **Blood Pressure:**  *(Latest reading/ any concerns/ may need lying/standing)* |  | | | **Date**: |  |
| **Vision:**  *(Wears glasses, visual impairment)* |  | | **Orthoptics referral done** | Yes / No | |
| **Date**: | | |
| **Activity plan provided & overview:**  *(upper limb, cognition, SLT, balance etc)* |  | | **Shown to family/Carers?** Yes / No | | |
| **Date**: | | |
| Outcome Measures: | Barthel |  | | Date: | |
| Modified Rankin |  | | Date: | |
| BERG |  | | Date: | |
| Cognition screen/ Score |  | | Date: | |
| Other: |  | | Date: | |

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| **Wellbeing** | | **Date completed:** |  |
| **Environment** *(safe/ appropriate/ supportive),* **Physical health** *(self-care/ pacing/ lifestyle choices),* **Emotional awareness** *(Resilience/ ability moving forward/ self-compassion*), **Mindset** *(Growth/ fixed/ patterns/ habits/ beliefs/ adaptability),* **Social connections** *(Supportive relationships which enable self-direction/ self-guiding),* **Time** *(How is there time spent in a meaningful, fulfilling and enjoyable way?),* **Identity** *(Current identity)* and **Spirituality** *(Living an autonomous, fulfilling, meaningful and enjoyable life)* | | | |
| Comments: |  | | |

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| **Patients’ rehabilitation priorities**  (Compelling outcomes/ Goals):  (Consider cognition, ability, rehab potential & wellbeing) | 1.  2.  3.  4. |

**Please telephone 01604 544275 if you do not receive a confirmation that your referral has been received.   
CST DO NOT accept responsibility for a referral without giving confirmation of receipt.**

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| **Speciality required**:  (please indicate) | Physiotherapy Yes/No | OT  Yes/No | SLT  Yes/No | | Nursing  Yes/No | | Wellbeing  Yes/No |
| **Referrer Name:** |  | | | **Referrer Role:** | |  | |
| **Date of Referral:** |  | | | **Contact Number:**  **Email:** | |  | |

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