NORTH LONDON PARTNERS in health and care

Community Stroke Rehab Team Referral

The referral will not be accepted without an EDC/medical discharge summary. To prevent delay, please complete all sections. To be used for all community referrals including ESD.

Patient Name:		Patient Preferred Name:
Expected discharge date:		Date of stroke onset:
Discipline(s) required: Physio ☐ OT ☐ SLT ☐ Psychology ☐		
CCG of residence: Barnet ☐ Camden☐ Enfield☐ Haringey☐ Islington☐		
Date of Referral:		Patient consent to referral: Yes ☐ No ☐
Referrer Name:		Referrer Role:
Referring Hospital and ward (or other):		
Referrer Telephone number/bleep:		
Referrer email/fax:		
NHS No:	D.O.B:	Gender:
Patient Permanent Address:		
Patient Current location (if different):		
Patient Telephone number (home):		(mobile):
GP Name and Surgery Name:		
GP Address:		
GP telephone number:		email/fax number:
Current Medications (Name, Dose, & Frequency→or attach medication list in D/C summary):		
Next of Kin / Carer/Nominated contact:		
NOK relationship:		NOK Telephone number:
Ethnicity:		Smoker: Yes ☐ No ☐ ex-smoker ☐
Is an interpreter required? Yes ☐ No ☐ which language?		
Specify any previous/ current communication difficulties/ requirements: Cognitive☐ Dysarthria☐ Aphasia☐		
Other services on discharge: Social Services ☐ Freq: Night Service ☐ Duration: Reablement Team ☐ Freq: District Nurses ☐ Mental Health Services ☐ *Other details:*		
Risk Factors and Access to property: Are there any known safety issues when visiting? Yes ☐ No ☐ Can the client provide access to the property? Yes ☐ No ☐ *Key Safe and code:* *If not, how:* Is patient safe over 24hour period (in between care calls) at home? Yes ☐ No ☐ Is the client living alone? Yes ☐ No ☐ History or risk of mental health illness, stress, self-harm/suicide, harm to others? Yes ☐ No ☐ Any problems with Drug/alcohol abuse? Yes ☐ No ☐ Anyone that could cause threats of violence? Yes ☐ No ☐ Are there other people or pets living in the client's home that could cause a risk? Yes ☐ No ☐ Any history of falls? Yes ☐ No ☐ Able to self-administer Medication? Yes ☐ No ☐ *If not, who will support:* Is the patient at risk of developing/has pressure sore? Yes ☐ No ☐ *where:* *Other (specify):*		

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Please attach stroke therapy proforma or therapy reports or outcome measures if available. If not available, complete the following:		
Function	Previous	Current
Transfers		
Mobility		
Stairs		
PADLs		
DADLs		
Cognition/Mood eg MOCA		
Level of care		
Swallow status		
Nutrition status		
Skin status		
Reason for referral and therapy comments (eg Voc rehab/ UL or LL/ tone & ROM/ equipment needs): ***NB: Referral will not be accepted without an EDC/Medical D/C Summary***		
Stroke Symptoms/impairments on discharge:		
Goals (Current and community goals)		

Barnet: Email form to: icsbarnet@nhs.net and must phone Single Point of Access on **0845 389 0940** to speak with clinical screener to discuss referral (fax: 0845 389 0941)

Camden: You must phone the screener to discuss the referral: **07747 461273.** The form can be completed by the screener over the phone or by emailing the completed form to: neuroscreener.cnwl@nhs.net

Enfield: Email form to: beh-tr.AdultCommunityTherapiesAdmin@nhs.net . Please ring the admin office on **020 8702 5660** and confirm the patient has been discharged.

Haringey: Email form to: haringey.adult-referrals@nhs.net and Cc. referral to whh-tr.ICTTStroketeam@nhs.net . To discuss the referral please call on **020 3074 2903**

Islington: Email form to arti.centralbooking@nhs.net on day of discharge. Must phone **07747 743543** to discuss referral.

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