NHS
Northampton General Hospital
NHS Trust

Community Stroke Team Patient Referral Form

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

Hospital No:		NHS No:	Essential
Patient Name:	Essential	Date of Birth:	Essential
Patient Home Address:	Essential	Address on Discharge (if different):	Please complete if address is different to the patient's usual address
Patient Telephone No:	Essential	Alternative Contact:	Essential – does not have to be next of kin
Patient spoken language:	Essential	Tel No:	Essential
Patient Email Address:	Essential	Alternative Contact Email Address:	Optional
Key Safe Number:	Please provide number		
Ethnicity/Cultural needs:	Essential	Hearing impairment?	Essential
Consultant:	Essential	Visual deficits?	Essential
Date of Stroke:	Essential	Food/ Fluid levels:	Essential
Type of Stroke:	Essential	Communication difficulties?	Essential
Thrombolysis:	Yes/ No Date:	GP Name	Essential
Ward/Hospital:	Essential	GP Surgery Address Post Code Telephone Number	Essential – this has to be a Northamptonshire GP
Discharge Date:	Essential		
DNAR/ ReSPECT form status:	Essential		
Any risks identified for lone workers?	No/Yes. If yes details: Essential, e.g. pets, issues on the ward to be aware of, safeguarding		
Relevant Medical History *(Physical health, mental health, health impacting limitations eg: lower limb OA)*	Essential		
Known Allergies	Essential		

Discharge & Care Plan			
Care Package in Place?	Yes/No	Number of care calls per day:	e.g. 4 x per day
Res DTA (residential discharge to assess bed)	Yes/No	Number of carers per care call:	e.g. 2 carers
Name of care provider & contact details:	Essential if care is provided	Total daily care minutes provided:	e.g. 30 mins x 4 calls =2hrs
		Number of days per week:	e.g. 7
Carers Duties: *(Personal care, meals, medication management, wash & dress etc)*	Essential if care is provided. e.g. washing & dressing, meal prep, medication, toileting	Date & Time of first Care Call:	Essential if care is provided
Reason for change in discharge destination & plans for returning home:	Please complete this if the patient does not return to their pre-admission address		
Long Term Care Plan: *(Length of care input or planned reduction in care)*	Essential if care is provided, is the aim to reduce the care e.g. reablement, or will it be a long term package?		
Family Support for ongoing care/rehab & Timescale:	Essential, please detail what support family are willing and able to provide.		

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Patient Name:	Essential	D.O.B	Essential	

Additional information:

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

Reason reablement required: Only complete this section if CST-Reablement are involved in the discharge.				
Reablement calls requested:	Morning Yes/No	Lunch Yes/No	Tea-time Yes/No	Evening Yes/No
Observations:	Waterflow:	Height:	Weight:	DNAR Status:

For All Patients:

Capacity Ax / Concerns around capacity:		Essential, include mental capacity assessments, best interest meetings or state if there is no reason to doubt capacity	
Initial Stroke Presentation/ symptoms:		Essential – brief overview of main initial presentation / symptoms	
Driving	Yes/No Essential	Driving Leaflet given to patient: Any comments?	Yes/No Essential
Pre-Stroke Hobbies/ Work/ Family/ Friends/ relationships/ Animals/ interests/ usual routine/baseline		Essential	

Equipment & Orthotics	Equipment Provided: *(Commode, perching stool, mobility aids, ramps etc)*	Essential if equipment was provided – please list what has been delivered
	Prescriber name and date delivered:	Essential if equipment was provided
	Orthotics Referral Completed/Referring therapist:	Yes/No Name:
	Date referral sent:	Helpful if date known
	Orthotics provided: *(AFO, shoulder cuff, WHO, Boxia etc)*	Essential if orthotics were provided – please list
	Orthotics regime: *(Is a plan in place, handed over to carers/family?)*	Essential if orthotics were provided – please detail orthotics regime and who is continuing this plan after discharge. Ideally work with the family/carers whilst in hospital to enable smooth transition after discharge.

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Stroke Rehab So Far:			
Physio: *(Strength/ sensation/ proprioception's/ co-ordination etc/ mobility/ transfers/ ongoing therapy)*	See prompts and aim to answer as fully as possible		
Spasticity Management: *(medication/ stretches shown/ botox clinic/ date)*	See prompts and aim to answer as fully as possible		
OT: *(Functional tasks- W&D, Kitchen, Cognition, home visit completed)*	See prompts and aim to answer as fully as possible		
SALT: *(Communication difficulties, swallow, diet, fluid/meals)*	See prompts and aim to answer as fully as possible		
Nurse *Overnight & day needs/ sleep/ fatigue/ mood concerns*	See prompts and aim to answer as fully as possible		
Medication Management: *(Self-managing/ family input/ medication changes/ reasons for change)*	See prompts and aim to answer as fully as possible		
Continence: *(Ongoing management plans, referral to continence nurse?)*	See prompts and aim to answer as fully as possible		
Blood Pressure: *(Latest reading/ any concerns/ may need lying/standing)*	Please detail latest reading	**Date**:	
Vision: *(Wears glasses, visual impairment)*	See prompts and aim to answer as fully as possible		
VISA Vison Assessment done? **Date:**	Yes / No *Add date assessment done*	**Orthoptics referral done:** **Date:**	Yes / No *Add date*
Activity plan provided & overview: *(upper limb, cognition, SLT, balance etc)*	What exercises / activities does the patient have to take home with them?	**Shown to family/Carers?** Yes / No **Date**:	
Outcome Measures:	Barthel	Essential	Date:
	Modified Rankin	Essential	Date:
	BERG	If completed	Date:
	Cognition screen/ Score	Essential, details whether formal e.g. OCS or informal e.g. assessed in function or not assessed	Date:
	Other:	If completed	Date:

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8 Keys to Recovery ©	
Recovery Environment *(safe/ appropriate/ supportive),* **Social Network** *(Supportive relationships which enable self-direction/ self-guiding),* ***Functional Ability*** *(Engages with meaningful activities, problem solves, paces and adapts),* ***Self-Care*** *(adequate rest, sleep, nutrition, hydration, good lifestyle choices),* **Recovery Mindset** *(Patient's thoughts, perspectives, values and inner dialogue which activates or hinders recovery),* **Emotional State** *(Able to identify, express, manage and regulate their emotions, able to overcome challenges),* **Identity** *(The patient holds the identity of the expert in their own recovery and is compelled, willing and able to self-direct)* and **Make everything rehab** *(How the patient makes everything they do within the course of their day in service of their rehabilitation).*	
Comments:	Essential, please detail any wellbeing concerns or interventions done. Think about their wellbeing around the above list of keys to recovery. What are activators and what are barriers for the patient.

Patients' rehabilitation priorities (Compelling outcomes/ Goals):	1. Please detail the patients rehab priorities. This replaces the previous SMART goals. These should be priorities which are important to the patient and they should be fully involved in developing and agreeing them. 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.

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