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** **cst.ngh@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 AddressPost 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: | MorningYes/No | LunchYes/No | Tea-timeYes/No | EveningYes/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/NoName: |
| 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) |  PhysiotherapyYes/No | OTYes/No |  SLTYes/No |  NursingYes/No |  WellbeingYes/No |
| **Referrer Name:** |  | **Referrer Role:** |  |
| **Date of Referral:** |  | **Contact Number:****Email:** |  |

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