City Hospitals Sunderland NHS
NHS Foundation Trust

Sunderland
Community Stroke Rehabilitation Team –Referral Form

Direct Line: 0191 569 9305 or ext. 41165 Fax: 0191 569 9306 or ext. 41063

PATIENT DETAILS

Name: …….. (Mr, Mrs, Miss, other) …….

Date of Birth: …… ……. Age: ……. Sex (M/F) ……

NHS Number: …….. Hospital X Number: ……..

Home Address: ……

……..... Postcode: ……..
Telephone Number Home: …….. Mobile: ……
Email: ……..

Marital Status: …….. …. Ethnic Group: ……
Language Spoken: …… Religion: ……..
Affiliation: ……

GP:…… Practice:……
Tel No: ……

NEXT OF KIN

Name: …… Relationship to Patient: ……

Address: ……

Contact Number/s (Home/Mob): ……..……

Current Location of Patient: (eg, Home, Ward) ……

Date of Admission (if in Hospital): …..……
Consultant & Specialty: ……

Medical Diagnosis/Details of CVA: ……..
……
Date of Event: ……
CT/MRI Date & Result: ……
……

MRSA: Yes/No (delete as appropriate) Date last Screened: ……..

Past Medical History	CVA/TIA PVD Diabetes Hypertension AF	Dates

Social History/Home Circumstances (including support & main carer)

Employment? Driver?
Smoker? Alcohol Consumption?

Medications
Antiplatlet Therapy:
Antihypertensive:
Statins:
Other:

Allergies:

Current Level of Mobility/Transfers (Aids/Equipment/Supervision/Support Required?)

Swallowing recommendations:

Weakness/hemi paresis from Stroke?

Communication Difficulties?

Cognitive/Perceptual Problems?

Visual Problems?

Continence:

MDT Currently Involved (please tick)
□ Named Nurse □ Physiotherapy □ Occupational Therapy □ Speech & Language Therapy
□ Dietician □ Social Worker □ Clinical Psychology □ Other (please state)……

Rehabilitation Needs

Patient/Family Aware of Referral/Consent Given? …….

Date: ……

Any Known Risks that Community Stroke Rehab Team need to be aware of? ……

……

SOURCE OF REFERRAL

Name of Referrer: ……..…….. Designation: …….

Location/Ward……..……. Contact No ……

Hospital: …….

Date of Referral: ……

For Community stroke Rehab Team to Complete

Referral Received(date)	
Accepted for assessment	
Not accepted for assessment	

Reason why not accepted ……

Referrer Informed (name/date) ……

Completed by CSRT Staffmember (name, signature) …… Date: ……