**BRIGHTON COMMUNITY NEUROLOGICAL REHABILITATION TEAM REFERRAL FORM**

Community Neurological Rehabilitation Team, D3, D Block, Brighton General Hospital, Elm Grove, Brighton. BN2 3EW

Tel: 01273 242271 Fax: 01273 254323 - 01273 682685 email: SC-TR.CNRTBrightonAndHove@nhs.net

**Important:** *Please ensure the patient meets the referral criteria before completing this form.* **Note:** *Referrals without all the information will be returned to the referrer and not considered for assessment by the service.*

**DATE COMPLETED: DISCHARGE DATE:**

**TYPE OF REFERRAL** *(Please circle*)**: ESD SERVICE CNRT**

*If referring to Early Supported Discharge Service, Please complete and attach the Stroke Triage Tool and discuss with the CNRT team to initiate the referral.*

**Patient details**

|  |  |
| --- | --- |
| Title:  | Date of Birth:  |
| Name:  | NHS Number:  |
| **Address:**  | Ethnicity: British |
| Full Name of Next of Kin: Landline (if different to patient): Mobile Telephone Number:  |
| GP Name: Organisation Code:  |
| Landline Telephone Number: Mobile Telephone Number:  | Referrer Name: Ward/Hospital: Solomon/RSCHTelephone Number: 01273 696955 ex 4590 |
| Hospital Consultant: Dr Kane |
| Have all the above details been checked with patient:  | YES NO (please circle)  |

**Medical History**

|  |
| --- |
| Current Diagnosis (*Date of onset, Scan/investigation results)*  |
| Past Medical History *(Include other medical conditions and Mental Health History)* |

|  |
| --- |
| Medication on discharge *(Or please provide medical discharge summary)* |
| BP and Pulse readings:  |
| **DNAR Status** (*Please attach copy of form)* |
| Infection Control Status |
| NPDS- ***state score*** | Allergies: See discharge summary |
| Waterlow: 1 | MUST:  |

**Social History**

|  |
| --- |
| *Environment, Key safe, Carelink* |

**Current Functional Status**

|  |
| --- |
| *Personal Care, Mobility, Toileting day/night, Medication management* |
| Communication |
| Continence |
| Swallow |

|  |
| --- |
| Current Suicidal Ideations/Mood  |
| Cognition |

**Rehab Goals**

|  |
| --- |
| ***SMART*** *Short and Long Term Goals, disciplines required* |

**CHECKLIST Yes No**

|  |  |  |
| --- | --- | --- |
| Does the patient require input from 2 or more disciplines? | X |  |
| Is the patient having a Package Of Care on discharge?- ***if ‘Yes’, please state details below*** |  |  |
| Has the referral been explained and the patient consented? | X |  |
| Is the required equipment and Pressure Care in place for discharge? |  |  |

**Additional Information –including any known risks to patients and/or staff (e.g. risk of falls, infection, violence etc.)**

|  |
| --- |
|  |