**Greater Manchester Community Stroke & Neuro Team Referral**

Intended pathway referral: Stroke [ ]  Neurorehabilitation [ ]

Stroke only: Date of stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this referral ‘as per protocol’ (No rehab goals): Yes [ ]  No [ ]

Did the patient drive before the stroke? Yes [ ]  No [ ]

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|  | **Patient Name:** | *(Please include preferred name if applicable)*  |
|  | **NHS Number:** |   | **Referring ward and hospital:** |  |
|
|  | **Date of Birth:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Consultant:** |  |
|
|  | **Patient’s address at discharge:***(inc. postcode)**Consider if patient is being discharged to 24-hour care, D2A bed, respite, relatives and if destination is temporary or permanent* |  | **Date** **Admitted:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date of Discharge:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Access arrangements:****Keysafe number:** |  |
|  | **Patient phone number:** |  | **Patient aware and consented of referral?** | \_\_\_\_\_\_\_ |
|  | **NOK name:** **Relationship:****Phone Number:** |  | **GP details:**  | Name:Address:Postcode:Telephone number: |
|  | **Resus Status:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of uDNACPR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Identified Risks to visiting staff:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Details: *(e.g. dog, family member etc)* |
|  | **Advanced care plans:** *(e.g. power of attorney)* |  | **Risk to Patient** | Details *(e.g. suicidal ideation/self-harm/safeguarding/substance abuse)* |
|  | **Preferred Language****Interpreter Required?** | Spoken:Written: | **Cultural Considerations:** *(e.g. religious/spiritual practice, food/drink, clothes, personal presentation, shared activities, relationships, cross-cultural communication)* |  |
|  | **Summary of admission:** | Primary Diagnosis:Details *(include scan results, investigations, dates, onset):* |
|  | **Previous Medical History:** |  |
|  | **Previous level of function:** |  |
|  | **Social history:** | *Include accommodation, employment, hobbies, significant relationships, previous support, substance abuse.* |
|  | **Care Package size, type, SW name:** |  |
|  | **Medication route:***(Please see medical discharge summary for details of medications)* |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Allergies:** | Yes or Nil known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Current status on discharge** (please send any relevant outcome measures) |
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| **Diet & Fluid Recommendations:** | Fluids:\_\_\_\_\_\_\_\_\_\_\_\_Date of last assessment: | Diet:\_\_\_\_\_\_\_\_\_\_\_\_Date of last assessment:  | **Additional recommendations***(e.g. teaspoon/tasters only, oral nutritional supplements)* |  |
| **VFS/FEES completed?** | Yes [ ]  No [ ] Details: | **Thickener type?****Provided?** |  |
| **Appetite:** | ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_  | Weight loss concerns?Details: | **Current weight (kgs):** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Swallowing:** | Details: *(include assessment findings)* |
| **Respiratory status:** | Independent [ ]  Needs help [ ]  Details:  |
| **Upper/Lower Limbs:** | Upper Limbs: No issues [ ]  Impaired [ ]  Details: | Lower Limbs: No issues [ ]  Impaired [ ]  Details: |
| **Transfers:**   | Independent [ ]  Needs help [ ]  Hoisted [ ] Details: *(inc. equipment needs and support required to use equipment)* |
| **Mobility and Balance:**  | Independent [ ]  Needs help [ ]  Wheelchair [ ] Bed Bound [ ] Details: |
| **Falls:** | Yes [ ]  No [ ]  Details: |
| **Personal Care:**  | Independent [ ]  Needs help [ ]  Details: |
| **Continence Management & Aids provided?** **Referred to Continence Service?** | **Bladder**Continent [ ]  Incontinent [ ]  Catheter [ ] Details:Yes/No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Bowel**Continent [ ]  Incontinent [ ]  Stoma [ ] Details: |
| **Communication:**  | Independent [ ]  Needs help [ ]  Level of functional communication:Details: *(Include diagnosis, assessments completed and scores)* |
| **Cognition:**  | No issues [ ]  Impaired [ ]  MOCA Score (if applicable):Details: *(include assessments and scores)* |
| **Behaviour:**  | Engaged in rehab [ ]  Challenging behaviour: Physical [ ] Verbal [ ]  Details: *(include behavioural guidelines)* |
| **Mood/Anxiety:** | No issues [ ]  Mild difficulties [ ]  Moderate difficulties [ ]  Significant difficulties [ ] Details: |
| **Vision:** | No issues [ ]  Impaired [ ]  Details: |
| **Skin Integrity:** |  |
| **Equipment Provided:** |  |
| **Positioning, Seating and Splinting:**  |  |
| **Vocational Rehab Needs:** |  |
| **Driving Advice/Needs:****Driver Type?****Seizures?** |  |

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| **Complete if primary stroke diagnosis** |
| **Have you provided the patient with the ‘My Stroke Document’?** | Yes/No: \_\_\_\_\_\_\_\_\_ |
| **Patient consented to information and referral being sent to Stroke Association?\*** | Yes/No: \_\_\_\_\_\_\_\_\_ |
| **Secondary Prevention Information:** *Please include details of: lifestyle advice, diabetes management, smoking cesation* |  |
| **Last 2 BP readings:** | **Systolic:** \_\_\_**Diastolic:** \_\_\_**Systolic:** \_\_\_**Diastolic:** \_\_\_ | **Monitoring advised?** | **Yes/No:** \_\_\_\_\_\_**Details:** |
| **Modified Rankin Scale:**\_\_\_\_\_\_\_\_\_\_ | **Barthel Score:**\_\_\_\_\_\_\_\_\_\_ |

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| **Complete if primary neuro diagnosis****RCS on discharge:** |
| Care: \_\_\_  | Risk: \_\_\_ | Nursing: \_\_\_ | Medical: \_\_\_ | Therapy disciplines: \_\_\_ | Therapy Intensity: \_\_\_ | Equipment: \_\_\_ |

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|  | **Rehabilitation needs on discharge** |
|  | **Disciplines Expected on Discharge and Identified Rehab Goals:** *(please ensure receiving service has access to below disciplines prior to referral)* | [ ]  Physiotherapy: (name of professional)[ ]  Occupational Therapy: (name of professional)[ ]  Speech Therapy: (name of professional)[ ]  Psychology: (name of professional)[ ]  Medical: (name of professional)[ ]  Specialist Nurse:(name of professional)[ ]  Dietician: (name of professional)[ ]  Other:(name of professional) | **Function on Admission:** |
| **Summary of rehabilitation and progress:** *(inc. treatments that have been attempted and achieved/not achieved)* |
| **Aim of referral:** |
|  | **Additional Information:**  | *(copies of exercises or care plans/rehab prescription/maintenance programmes/outcome measures, any mental capacity concerns)* |
| **Referrals made to other agencies:**  | *(inc. specialist nurse, continence team, voluntary sector - stroke & neuro)* Please include contact details as able |
| **Referrer details** | PRINT name:Designation:Contact Number: | **Date of** **referral:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

\*If stroke diagnosis, please ensure this referral is also sent onto the Stroke Association in the area the patient resides. Please ensure you have requested/discussed consent from the patient (or family if patient unable) for details to be shared and for follow up support to be offered by the Stroke Association.