**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) | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **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):** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **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.