|  |
| --- |
| ***Please check your client meets all criteria before completing this form.***  *Incomplete referrals or referrals not meeting the service criteria will be returned to the referrer.*  *Transfer summaries, clinic letters, rehabilitation prescriptions and discharge reports, while useful, cannot be accepted in place of a completed referral form.*  *Please be aware that, as a therapy team, we are not able to provide information and/or advice on medical management issues.  Delays in providing relevant information at referral may cause unnecessary delays in service provision.* |

***REFERRAL CRITERIA CHECKLIST*** Tick if yes:

|  |  |
| --- | --- |
| The client is registered with a **Shropshire or Telford & Wrekin GP** |  |
| The client requires **specialist rehabilitation** for a **neurological condition** |  |
| The client has had either a **recent** neurological event/relapse or a **significant** change of circumstance |  |
| The client is **medically stable** |  |
| The client requires **time-limited** input from **two or more** therapy disciplines |  |
| The client has **rehabilitation potential** with **clear, functional goals** already identified |  |
| The client has **consented** to the referral or, in the case of individuals with severe cognitive deficit, referral is deemed to be in their **best interest** and consent has been gained from an appropriate source (e.g. appointee) |  |
| The client is **motivated** to **actively engage** in rehabilitation activities |  |

***CLIENT’S DETAILS***

|  |  |  |
| --- | --- | --- |
| **First name(s):** | | **Address:** |
| **Last name:** | |
| **NHS number:** | |
| **Date of birth:** | |
| **Telephone:** | |
| **Other contact:** | | **Post code:** |
| **Gender:** Male🞏 Female 🞏 Other: | | **Ethnicity:** |
| **Does client have a learning disability?** Yes🞏 No 🞏 | **1st language (if not English):** | |
| **GP:** | | |

***MEDICAL HISTORY***

|  |  |
| --- | --- |
| **Diagnosis:** | **Date of onset:** |
| **Scan/investigation results:** | |
| **Background information:** | |
| **Current medication:** | |
| **Alerts/allergies:** | |
| **Relevant co-morbidities/past medical history:** | |

***REFERRAL DETAILS*** *[please note that if this information is not* ***clear and explicit*** *then we reserve the right to decline the referral and return the form]*

|  |
| --- |
| **Date of referral:** |
| **Referrer’s name:** |
| **Referrer’s role:** |
| **Referrer’s contact details:** |
| **Referral reason:** *[why do you think this client requires specialist, multidisciplinary team input from the Community Neuro Rehab Team?]* |
| **Anticipated therapy requirement:** *[please tick all that apply]*  Clinical Psychology  Occupational Therapy  Physiotherapy  Speech and Language Therapy |
| **Client’s goals/expectations of treatment:** |
| **Client’s current support network:** *[please include formal and informal care support]* |
| **Client’s current problems/functional level:**  PHYSICAL:  FUNCTION:  COMMUNICATION/SWALLOWING:  SOCIAL/BEHAVIOURAL:  MOOD/EMOTIONAL:  COGNITIVE: |

***SUPPORTING INFORMATION*** *[please tick all that apply]*

|  |
| --- |
| **Is client currently in hospital, or had a recent hospital admission?** Yes  No  If Yes, please provide hospital name, ward name and planned or actual discharge date: |

|  |  |
| --- | --- |
| **Is client able to attend an outpatient setting?**  Yes  No | **Any special requirements?**  Wheelchair  Transport  Escort  Assistance with personal care  Other: |

|  |
| --- |
| **Are there any other services involved or planned?** Yes  No  If Yes, please provide details of service and named contact(s): |

|  |
| --- |
| **Are there any risk(s) associated with this patient or their home?** Yes  No  If Yes, please provide details of risk and suggested management plan: |

|  |
| --- |
| Please return your completed form to **shropcom.cnrt@nhs.net** or contact us on  **01743 453600** if you require further assistance |

*Please do not hesitate to contact us if you have any questions about making a referral or completing this form.*

*Incomplete forms may be returned. Where possible, please include additional information such as discharge reports, assessment reports, results of investigations, and/or EMIS printouts – thank you.*