

Community based neuro-rehab (CBNRT) team referral form

Please ensure client being referred is medically stable
IMPORTANT: client must meet criteria (shaded boxes) before completing the referral
This form must be completed in full and clear. Incomplete forms will be returned to sender

	Yes
The client must be registered to a Berkshire West GP to receive this service	
Does the client have a complex neurological condition ?	
Does the client have impaired physical, cognitive and/or communication function ?	
Does client have short term rehab potential ?	
Has the client consented to the referral? Please inform them that the referral will be screened prior to acceptance.	
The screening process may involve a telephone screen – can the patient engage in this? If 'no' please state why:	

Patient's Details

NHS No:	Date of Birth:
Title:	Ethnicity:
Forename(s):	Surname:
Address:	Next of Kin name for contact: Should this be the main contact for the patient? Please explain why:
Postcode:	Relationship:
Telephone No:	Telephone No:
Consent to leave message:	Consent to leave message:
Communication requirement: e.g. hard of hearing <input type="checkbox"/> requires a translator <input type="checkbox"/> unable to use phone <input type="checkbox"/> Other, please state (e.g. enlarged print letters):	
Current location of patient:	
Planned discharge date:	

Medical History:

Diagnosis: Date of onset: Scan/ investigation results:	Past Medical History:
Medication:	Rehab to date:
Social History: <i>*Please include details of accommodation, carer support, risk factors e.g. dogs, visit in pairs*</i>	
Present Functional Ability: <i>e.g. related to communication, mobility, daily living tasks, care needs</i>	
Disciplines/services currently/recently involved:	
Known risks (please state):	

Reason for referral and specific short term rehab goals / outcomes:

NB: *Equipment required i.e. rails/orthotics must addressed prior to referral being made to CBNRT*

Please ask the individual and all team members involved for their goals

Please attach any relevant reports

Disciplines Required:

Occupational Therapy Physio Speech and language Neuropsychology

Doctor's Details:

Registered GP Surgery & Address:	Consultant name and other professionals involved:
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Referrer Details:

Name:	Profession:
Address:	Telephone:
	Date:
Postcode:	

Return completed form to:

BHFT Referral Hub	Tel: 0300 365 1234
	Email: Integratedhub@berkshire.nhs.uk

CBNRT Admin Contact
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