

## Community based neuro-rehab team referral form

- Referrals that do not contain the information shaded in peach will be returned.
- Complete the rest of the form with as much information as possible, this assists screening and prioritisation
- Ensure that the following acceptance criteria are met prior to referring:

Clients must be registered with a Berkshire West GP to access this service

Clients must have a complex neurological condition with one or a combination of physical, cognitive and communication needs that require specialist Neuro Rehabilitation

Clients must be medically stable and able to engage in rehab

Clients must have **consented to referral**. Please inform them that the referral will be screened prior to acceptance.

## Return completed form to:

| BHFT Referral Hub  | Email: Integratedhub@berkshire.nhs.uk Tel: 0300 365 1234 |  |
|--|--|--|
| If you would like to discuss the appropriateness of a referral, please call CBNRT on |  |  |
| 0118 904 3440  |  |  |

## Patient's Details:

| NHS No:   | Date of Birth:                                   |  |  |
|---|--|--|--|
| Title:  | Ethnicity:                                       |  |  |
| Forename(s):  | Surname:   |  |  |
| Address:  | Next of Kin name:                                |  |  |
|   | Relationship:                                    |  |  |
|   | Should this be the main contact for the patient? |  |  |
| Postcode:   | Yes □ No □                                       |  |  |
| Telephone No:   | Please state reason why:                         |  |  |
| Consent to leave message: Yes □ No □  | Telephone No:                                    |  |  |
| (this helps us to get in touch with the patient more easily)                | Consent to leave message: Yes □ No □             |  |  |
| Email:  |  |  |  |
| Communication requirement: hard of hearing□ requires a translator□ language |  |  |  |
| unable to use phone□  |  |  |  |
| Other, please state (e.g. enlarged print letters):                          |  |  |  |
|   |  |  |  |

| The screening process may involve a telephone screen - can the patient engage in this? Yes  No□If 'no' please state why:                   |   |  |  |  |
|--|---|--|--|--|
| Current location of patient if not at home:  |   |  |  |  |
| Planned discharge date if an inpatient:  |   |  |  |  |
| Registered GP Surgery & Address:   | Consultant name and other professionals involved: |  |  |  |
| Reason for Referral specific short term rehab goals (this must be completed for at least one discipline or else referral will be returned) |   |  |  |  |
| Physiotherapy:   |   |  |  |  |
| Occupational Therapy:  |   |  |  |  |
| Speech and Language<br>Therapy:  |   |  |  |  |
| Neuro Psychology:  |   |  |  |  |
| Nourological Diagnosis and Data of One   | ot·   |  |  |  |
| Neurological Diagnosis and Date of Onset:  |   |  |  |  |
| Scan/ investigation results:   |   |  |  |  |
|  |   |  |  |  |
| Past Medical History:  |   |  |  |  |
|  |   |  |  |  |
|  |   |  |  |  |

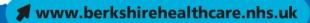














| Recent Rehab History and Present Functional Ability e.g. related to communication, mobility, daily living tasks, care needs. Please include location of inpatient therapy or community teams previously involved |  |
|--|--|
|  |  |
| Known risks (please state): either to patient e.g. falls risk, carer breakdown, employment, swallowing, mental health Or to health professionals visiting the home e.g. dogs                                     |  |
|  |  |
|  |  |

## **Referrer Details:**

| Name:     | Profession: |
|-----------|-------------|
| Address:  | Telephone:  |
|           | Date:       |
| Postcode: |             |











