Berkshire Healthcare
NHS Foundation Trust

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: Postcode:	Next of Kin name: Relationship: Should this be the main contact for the patient? Yes ☐ No ☐ Please state reason why:
Telephone No:	Telephone No:
Consent to leave message: Yes ☐ 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 Therapy:	
Neuro Psychology:	

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:	