|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  | | --- | | **The Community Neurological Rehabilitation Team accepts referrals for patients who have a confirmed neurological diagnosis with the primary need being related to this diagnosis who are registered with a Newcastle-under-Lyme G.P. or surrounds.**  The team CANNOT accept referrals for:   * Patients without a confirmed neurological diagnosis or the primary need is not related to the neurological condition – please refer to core services via the Therapy Hub (0300 123 0991) * **Wheelchair Assessments Only** – please refer to OPCARE (01782 216940) * **Major Home Adaptations** – please refer to Millbrook (0330 124 7077) North Staffordshire residents or SCOTS (01782 236950) Stoke-on-Trent residents * **Splinting and Footwear** – please refer to Orthotics (01782 976500) * **Patients who can attend out patient services** – please refer to appropriate services CNRT is domiciliary only | | | | |
| **Patient details** | | | |
| **Name:** | | **Title: Mr/ Mrs/Miss / Ms / Other** | **Male/female** |
| **Address:**    **Post Code** | | **Date of birth:** | |
| **NHS number :** | |
| **Telephone number:** | |
| **Mobile number:** | |
| **Interpreter/Sign Language required? Yes / No**  **Please specify:** | |
| **Preferred language:** | | **Ethnicity Please state:** | |
| **Patient GP’s details** | | **Carer/Next of Kin details (if applicable)** | |
| **GP’s name:** | | **Name:** | |
| **GP’s practice address:**  **Postcode:** | | **Address:** | |
| **Telephone Number:** | | **Telephone Number:** | |
| **Contact Details (for arranging appointments if different to above)** | | | |
| **Name:** | | **Relationship to patient:** | |
| **Telephone Number:** | |  | |
| **Reasons for requesting an assessment (If necessary please complete on a separate sheet)** | | | |
| **Patient Consented for referral:**  **Yes/No** | **Is the patient able to attend out patient appointments? Yes/No**  **If Yes refer to out patient services. CNRT is domiciliary only.** | | |
| **Specify Confirmed Neurological Condition/Diagnosis** |  | | |
| **Reason for Referral** –  Must include:  How the above neurological condition is currently affecting the patient |  | | |
| **Relevant medical history**  **Allergies**  **Pacemaker Yes/No**  **Medication (medication summary may be attached)**  **X-ray reports**  **Clinical Signs** |  | | |

**The Community Neurological Rehabilitation Team consists of Physiotherapy and Occupational Therapy. Please indicate if the referral is for either:**

Physiotherapy Occupational Therapy Joint Physio/OT Assessment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Reason for Domiciliary Visit (Please provide as much details as possible)** | | | | | |
| **Patients Perceived Problems** |  | | | | |
| **Has the patient consented to the referral to CNRT?** | Yes/No | |  | | |
| **Is the patient off work due to this episode?** | Yes/No/NA | |  | | |
| **Risk of Falls (Please detail)** | Yes/No | |  | | |
| **In Need of Mobility Assessment** | Yes/No | |  | | |
| **Are There Any Risk Markers Against The Patient/Family or Environment? (Please detail)** | Yes/No | |  | | |
| **Any Recent Hospital Admissions?**  **Please specify where and why** | Yes/No | |  | | |
| **Other Agencies/Professionals Involved? (Please detail)** | Yes/No | |  | | |
| **Additional Information** | | | | | |
| **Access to Home?**  e.g. Key safe code, access at back, walk way etc. |  | | | | |
| **Any Communication Difficulties?**  **(Please detail)** |  | | | | |
| **End of Life Care Pathway** | Yes/No | **Date Commenced** | | | |
| **Smokes** | Yes/No | **Support Given** | | | Yes/Declined |
| **Referrer Contact Details (Please Print)** | | | | | |
| **Name** | | | | **Designation** | |
| **Telephone Contact** | | | | **Base** | |
| **Email** | | | | **Date** | |