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| **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
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| **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

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| **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** |