**Integrated Community Stroke *(& Neuro- Coventry Only)* Services**

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| *Coventry CINSS Team*  ***Stroke and Neurology*** | Email:  [cwp-tr.adminsupport@covwarkpt.nhs.uk.](mailto:cwp-tr.adminsupport@covwarkpt.nhs.uk.)    *Tel: 0300 2000 395* |
| *Warwickshire WCSS Team*  ***Stroke Only*** | *Email:* [*strokecommunity@swft.nhs.uk*](mailto:strokecommunity@swft.nhs.uk)  *Tel: North: 024 75189191*  *Tel: South: 01926 317731* |

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| **Referral:** please tick the TEAM | | **PATIENT DETAILS (Patient hospital sticker if available)** |
| **Active Rehabilitation Pathway** |  | **Name:**  **DOB: fghfgh**  **NHS Number:**  **Address:** |
| ***For Consideration***  **Less than 4 weeks from date of stroke**  **Mobile with 1 or Indep if living alone** |  |
| **Neuro Management Pathway** |  |

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| **PATIENT DETAILS** | | | | |
| **Tel No (Home)** | | **Tel No (Mobile)** | | |
| Spoken Language: | Ethnic Origin: White British | | | Religion |
| Interpreter Required?: YES NO *(Please Circle)* | | | |
| **NEXT OF KIN DETAILS** | | | | |
| Name: | | | Tel. No. (Home) | |
| Relationship to Patient: | | | Tel No. (Mobile) | |

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| **REFERRER:** | | | | **GP DETAILS** |
| Name:  Contact Number for Referrer: | | | | GP Name: |
| Ward/Location: | | | | GP Address: |
| Date of referral: | | | | GP Tel No: |
| **POC REQUIREMENTS FOR DISCHARGE** | | | | **DISCHARGE DETAILS:** |
| **Warwickshire** (please tick) | | **Coventry**(please tick) | | Estimated discharge date: |
| ESD plus care |  | STSMI |  |
| Rehab at Home POC (not for South Warks) |  | Rehab at Home POC |  | Proposed discharge destination: |

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| **PRESENTING NEUROLOGICAL CONDITION** |
| **Diagnosis:**  **Date of stroke:**  **Scan Results:**  **Cognitive Assessment Completed (name of assessment):**  Date of assessment:  Is Cognitive assessment attached to referral? **Yes/No** (delete as appropriate) |
| **History of Present Condition:** |
| **Past Medical History:** |
| **Social History:**  (Consider who lives with, type of accommodation, POC needs) |
| **Considered Risks** (Consider Physical, Cognitive, Environmental, Consent and Capacity Issues, Lone Worker Risk, Carer Breakdown, Drug and Alcohol Mis-use, Safeguarding, Domestic Violence, Mental Health History or other known risks.) |
| **Reason for Referral to Specialist Therapy Service** |
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| **Progress to Date** |
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| **Any Other Relevant Information** |
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