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

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| *Coventry CINSS Team* ***Stroke and Neurology*** | Email: cwp-tr.adminsupport@covwarkpt.nhs.uk.*Tel: 0300 2000 395*  |
| *Warwickshire WCSS Team****Stroke Only***  | *Email:* *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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