

Community Neurological Rehabilitation Service

Rayners Hedge

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Aylesbury

Buckinghamshire. HP21 7RD

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**Providing Community Neurological Rehabilitation at:**

* Amersham Hospital
* Chalfonts & Gerrards Cross Hospital
* Rayners Hedge

**COMMUNITY NEUROLOGICAL REHABILITATION SERVICE REFERRAL FORM**

Please forward to: Service Lead, at above address or via email

buc-tr.CNRS@nhs.net **only if you have an nhs.net account, which ensures safe transfer of data.**  No other email is accepted due to data security risks.

**IF NOT COMPLETED FULLY, THE REFERRAL WILL BE RETURNED FOR COMPLETION**

**REFERRALS FROM ANONYMOUS REFERRERS WILL BE REJECTED.**

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| **Referrer Details (please complete in capitals)**  |
| Name:  | Job Role:  |
| Organisation: |
| Contact details:  |
| Phone No:  | Email:  |
| Is client aware of referral YES/NO  |
| Is the client happy to be contacted by video call? YES/NO |
| **Date of Referral:**  | **Time:**  |
| **Signature of Referrer:**  |
| Patient’s GP name and address Telephone: **(Bucks CCG only accepted)** |
| **Patient Name:**   | **NHS NO:**  |
| Mobile Telephone:  | Home Telephone:  |
| Address:  |
| Date of Birth:  | Age: | Ethnicity: |
| **Recent Diagnosis:**  | **Date of Onset**  |
| **Next of Kin name and address**  | Telephone:  |
| **Dependents**  |
| If patient not at usual address – current location? Telephone: Date of discharge from Hospital/Unit if relevant: Consultant’s name and contact details:  |
| **Reason for referral and Rehabilitation Goals Identified for ongoing therapy:****If goals are not identified for therapy - the referral will be returned** |
| **Request for Professional Assessment**Please **underline or Highlight** relevant disciplines and priority rating below |
| Physiotherapy  | Clinical Psychology  |
| Occupational Therapy  | Speech & Language Therapy  |
| **Priority**High (initial assessment within 8 weeks)  | Routine (initial assessment more than 8 weeks)  |
| **If treatment is required, there will be an additional wait due to high demand for the service**  |
| **Relevant medical management details and interventions** (scan results, surgery, investigations, allergies, **medication**)**PLEASE ATTACH MEDICAL REPORTS AND THERAPY/DISCHARGE REPORTS** **Failure to provide a full medical report could impede our ability to process the referral.** |
| **Recent Professional Involvement - Name and telephone number** |
| District/Named Nurse |  |
| Nurse Specialist |  |
| Physiotherapist |  |
| Occupational Therapist |  |
| Speech and Language |  |
| Dietician |  |
| Psychologist  |  |
| Care Manager |  |
| Other: |
| **Current Difficulties –** Please **underline/highlight** relevant problem areas below |
| **Bladder and Bowels** |
| Fully continent bowel and bladder  | Incontinent: night day  |
| Urinary | Bowel  |
| Requires bowel management  |
| **Emotion/Behaviour**  |
| Anxiety | Low Mood | Suicidal Ideation |
| Frustration/Anger | Mental Health History | Difficulties accepting health condition |
| Currently involved in Mental Health Services |
| **Comments:**  |
| **Cognitive** (e.g. Memory, perception, executive function) |
| Memory  | Attention/Concentration | Speed of processing |
| Planning/Organising | Personality change  | Disinhibition |
| Comments: |
| **Mobility**  |
| Independent  | Non walking  | Uses walking aid  |
| Comments:  |
| **Communication and speech**  |
| Expressive difficulties | Receptive difficulties | No difficulties |
| Aids used – please state |
| **Swallowing**  |
| Coughing/choking on food or drinks     | Recent chest infections (last 3 months) |
| Other: |
| **Sleep**   |
| Wakes in night  | Hard to go to sleep  |
| Sleeps through night  | Sleeps during the day |
| **Safety Issues** |
| Lives alone  | Behaviour /Wandering  |
| Comments:  |
| **Work status**  |
| Employed  | Unemployed  | Off sick  | Retired |
| **Areas of Difficulty in Activities of Daily Living**  |
| Washing and Dressing Routine  | Toileting Needs  |
| Transfers from chair/bed etc. | Domestic Tasks |
| Community Living Tasks  | Caring for Dependants  |
| Leisure Activities  | Work responsibility  |
| Comments:  |
| **Client Referred to Early Supportive Discharge Team for Stroke:** YES /NO |
| Expected date of therapy starting: |
| Expected date of therapy finishing: |
| **Other Services involved on discharge:** Please make **bold/underline** all involved services |
| Adult Community Healthcare Team  | Community Services  |
| Diabetes  | Social Services  |
| DNS  | Cardiac Services  |
| Orthopaedic  |  |
| Specialist Nurse (please specify): |