

Community Neurological Rehabilitation Service

Rayners Hedge

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Aylesbury

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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](mailto: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): | | | | | | | | | | | | | | |