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| Wandsworth CNRT/ESD  | Tel: 020 8812 4060Fax: 020 8812 4059 |  |  |  |  |

 |  | SGHcol |

**STROKE EARLY SUPPORTED DISCHARGE REFERRAL FORM**

|  |
| --- |
| Name: DOB:Address: Telephone No: NHS No: Post code: Ethnicity:  |
| GP:Address: Postcode: Tel: Fax:  |
| Date of referral: Referring Hospital**:** Planned date of discharge: Consultant: Ward: Tel No. & Ext: |
| Hospital Contact names and number (bleep or extension) |
| Physio: | No: | OT:  | No: |
| SLT: | No: | Nursing: | No: |
| Next of Kin: Telephone No: Relationship to person:  |
| Past medical history |
| Diagnosis (including scan result and date/s):  |
| Date of admission to HASU: Date of Admission to SU: |
| History of presenting condition:  |
| Social History:Lives with: Alone [ ]  Spouse/Partner [ ]  Other: Language spoken: Interpreter required? [ ] Previous package of care:Working Y [ ]  N [ ]  Occupation:Driving Y [ ]  N [ ]  Has patient been advised regarding driving restrictions?  |
| ***DISCHARGE PLANS:*** |
| Discharge destination:Package of care organised: District nursing referral made: Y [ ]  N/A [ ] . Input requested: Access Arrangements: Able to answer door [ ]  Family [ ]   Keysafe *(please provide ESD team with no)* [ ]  Other: Any known risks for therapists visiting: Adequate cognitive and communication ability to be considered safe [ ] Equipment in place Y [ ]  N/A [ ]  Details:Any referrals made to other services (e.g. Wheelchair, SSOT):  |

|  |  |
| --- | --- |
| ***Pre-morbid ability*** | ***Current ability*** |
| ***MOBILITY:*** *Any assistance or equipment required* |
| Transfers: Indoor Mobility: Stairs: Outdoor Mobility: Falls History: | Transfers: Indoor Mobility: Stairs: Outdoor Mobility: |
| ***PERSONAL CARE:*** *Any assistance or equipment required* |
| Washing/bathing:Dressing:Toileting: | Washing/bathing:Dressing:Toileting: |
| ***FEEDING:*** *Any assistance or equipment required* |
|  |  |
| ***MOOD:*** *Provide details* |
|  | Details of any onwards referral completed: |
| ***PAIN:*** *Provide details* |
|  |  |
| ***SKIN:*** *Provide details of pressure sores/ability to relieve/management plan* |
|  |  |
| ***CONTINENCE:*** |
| Bladder:Bowel: | Bladder:Bowel:Continence strategy in place Y [ ]  N/A [ ]  Details: |

|  |  |
| --- | --- |
| ***Pre-morbid ability*** | ***Current ability*** |
| ***COMMUNICATION:*** *Provide details and severity of impairments* |
|  |  |
| ***VISION:*** *Provide details* |
|  | Details of any onward referral completed: |
| ***HEARING:*** |
|  |
| ***SWALLOWING:*** |
| Dysphagia Y [ ]  N [ ] Severity:Status: Full oral intake [ ]  Limited oral trials with PEG feeds [ ]  Nil oral with PEG feeds only [ ] Diet: Puree [ ]  Fork mashable [ ]  Soft [ ]  Normal [ ] Fluids: Normal [ ]  Thickened [ ]  Syrup/custard/pudding thick:......scoops thickener per 200mls [ ] Saliva management: Adequate [ ]  Inadequate [ ] Meds: Oral [ ]  Non-oral [ ]  Strategies: |
| ***COGNITION AND BEHAVIOUR:*** |
| General cognitive presentation / Findings of cognitive screen:Do difficulties impact on the ability to engage in therapy? Y [ ]  N [ ] Please explain if yes:Name of standardised assessment:Date completed: Score: |
| ***OUTCOME MEASURES AT DISCHARGE:*** |
|  | Date Completed: | Score (or attach sheet): |
| FIM FAM |  |  |
| Berg Balance Scale: |  |  |
| Barthel Index: |  |  |
| MOCA: |  |  |
| *Other:*  |  |  |

***CURRENT THERAPY:*** *(please provide details on current intervention, progress made and future goals)*

**Physiotherapy:**

**Speech and Language Therapy:**

**Occupational Therapy:**

**Nursing:**

**Dietitian:**

**Other:**