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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Wandsworth CNRT/ESD | Tel: 020 8812 4060  Fax: 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:**