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| **Wandsworth Community Neuro Team****REFERRAL FORM** |

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| For office use only |
| Date of Ref received  |
| FORM MUST BE COMPLETED IN FULL TO AID PRIORITISATIONINCOMPLETE FORMS WILL BE RETURNED |
| Surname: Click here to enter text.  | First Name: Click here to enter text. |
| Mr [ ]  Mrs [ ]  Ms [ ]  | DoB: Click here to enter text. | NHS No:Click here to enter text. |
| Address & Postcode: Click here to enter text. | Tel. No: Click here to enter text. Ethnicity code: Choose an item. |
| NoK: Click here to enter text.Relationship to patient: Click here to enter text.NoK Tel No: Click here to enter text. | Does the person live alone? Can they answer the telephone?Do they require an interpreter?Language: Click here to enter text.Communication difficulties? Details: Click here to enter text.Package of care?Provider name: Click here to enter text. | Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ] Yes [ ]  No [ ] Yes [ ]  No [ ]  |
| Are there any RISKS we should be aware of?Click here to enter text. |
| GP Name: Click here to enter text.Consultant’s Name: Click here to enter text. | GP Address: Click here to enter text.GP Tel No.: Click here to enter text. |
| Referred by (Name & Team)Click here to enter text. | Referrer’s Address: Click here to enter text.Referrer’s Tel No.: Click here to enter text. |
| Neurological diagnosis:Click here to enter text.Date of onset: Click here to enter text.Hospital discharge date: Click here to enter text. | Past Medical History and relevant medication:*(Please include therapy reports, medical letters, EMIS reports)*Click here to enter text. |
| Current function and care needs:Click here to enter text. | Reason for referral to the Community Neuro Team: |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Current services involved:*(e.g. medical, therapy, social services)*Click here to enter text. | Does the patient have any key goals: |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Has the patient consented to this referral?  | Yes [ ]  No [ ]   |

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| **Wandsworth Community Neuro Team contact details:** |
| St John’s Therapy Centre162 St John’s Hill London SW11 1SW | 🕿: 0208 725 8050🖂: wandsworthcnt@stgeorges.nhs.uk  |
| **Referral criteria:** |
| People aged 16 and over, who have a Wandsworth GP and a primary neurological diagnosis.  |
| We offer:1. Neurological rehabilitation - Assessment, goal planning and intervention.
2. Long term disability management - Action planning, problem solving and inter-agency working.
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| We are a multidisciplinary team of Physiotherapists, Occupational therapists, Speech and Language Therapists, Clinical Psychologists, Clinical Nurse Specialist, Neuro Case Manager and Therapy Technical Instructors. |
| **Referrals not appropriate for our team** |
| **Reason for referral/problem** | **Appropriate team** |
| Adults without a primary neurological diagnosis who require therapy input  | Maximising Independence Team 0333 300 2350 |
| Provision of ADL equipment and/ or home adaptations only | Social Services Occupational Therapy via Access Team 020 8871 7707accessteam@wandsworth.gov.uk |
| Assessment for wheelchair provisionWheelchair repairs/ maintenance/collections | Wheelchair services - 020 8487 6084/5Opcare – 0204 505 3500 |
| Provision of hospital beds or pressure relief | District Nurses 0333 300 2350 |
| Provision of orthotics only | Orthotics clinic 020 8487 6055 |
| Stuttering/stammering | www.citylit.ac.uk |
| Referral for Psychology input only **or** Psychology input that is not related to a neurological diagnosis (e.g. premorbid mental health difficulties) | Talk Wandsworth 0203 513 6264talkwandsworth@swlstg-tr.nhs.uk  |
| Speech therapy for head and neck cancer **or** Voice therapy  | Adult Voice, Head and Neck/ENT Therapy TeamLanesborough WingSt George’s University Hospital NHS Foundation Trust |