Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

COMMUNITY BASED NEURO-REHAB TEAM REFERRAL FORM

Please ensure client being referred is medically stable
IMPORTANT: client must meet criteria (shaded boxes) before completing the referral
This form must be completed in full and clear. Incomplete forms will be returned to sender

	Yes
The client must be registered to a **Berkshire West GP to** receive this service	
Does the client have a **complex neurological condition?**	
Does the client have **impaired physical, cognitive and/or communication function**?	
Does client have **short term rehab potential**?	
Has the client **consented** to the referral? Please inform them that the referral will be screened prior to acceptance.	
The screening process may involve a telephone screen – can the patient engage in this? If 'no' please state why:	

Patient's Details:

NHS No:	Date of Birth:
Title:	Ethnicity:
Forename(s):	Surname:
Address:	Next of Kin name for contact:
Wokingham	Should this be the main contact for the patient?
	Please state reason why:
Postcode:	Relationship:
Telephone No: Consent to leave message:	Telephone No: Consent to leave message:
Communication requirement: e.g. hard of hearing☐ requires a translator☐ unable to use phone☐ Other, please state (e.g. enlarged print letters): ……..	
Current location of patient:	
Planned discharge date:	

Medical History:

Diagnosis: **Date of onset**: **Scan/ investigation results**:	**Past Medical History**:

Medication:	**Rehab to date:**

Social History:

Please include details of accommodation, carer support, risk factors e.g. dogs, visit in pairs

Present Functional Ability: ***e.g. related to communication, mobility, daily living tasks, care needs***

Disciplines/services currently/recently involved:

Known risks (please state):

Reason for referral and specific short term rehab goals / outcomes:

NB: *Equipment required i.e. rails/orthotics must addressed prior to referral being made to CBNRT*
Please ask the individual and all team members involved for their goals
Please attach any relevant reports

Disciplines Required: Occupational Therapy☐ Physio☐ Speech and language☐ Neuropsychology☐

Doctor's Details:

Registered GP Surgery & Address: Postcode: Telephone Number:	Consultant name and other professionals involved:

Referrer Details:

Name:	Profession:
Address:	Telephone:
	Date:
Postcode:	

Return completed form to:

BHFT Referral Hub	**Tel: 0300 365 1234** **Fax: 0300 365 0400** **Email: bks-tr.hub@nhs.net**

CBNRT Admin Contact
01635 273303