

Community based neuro-rehab team referral form

<ul style="list-style-type: none"> • Referrals that do not contain the information shaded in peach will be returned. • Complete the rest of the form with as much information as possible, this assists screening and prioritisation • Ensure that the following acceptance criteria are met prior to referring:
Clients must be registered with a Berkshire West GP to access this service
Clients must have a complex neurological condition with one or a combination of physical, cognitive and communication needs that require specialist Neuro Rehabilitation
Clients must be medically stable and able to engage in rehab
Clients must have consented to referral . Please inform them that the referral will be screened prior to acceptance.

Return completed form to:

BHFT Referral Hub	Email: Integratedhub@berkshire.nhs.uk Tel: 0300 365 1234
If you would like to discuss the appropriateness of a referral, please call CBNRT on 0118 904 3440	

Patient's Details:

NHS No:	Date of Birth:
Title:	Ethnicity:
Forename(s):	Surname:
Address:	Next of Kin name:
	Relationship:
	Should this be the main contact for the patient?
Postcode:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone No:	Please state reason why:
Consent to leave message: Yes <input type="checkbox"/> No <input type="checkbox"/> (this helps us to get in touch with the patient more easily)	Telephone No:
Email:	Consent to leave message: Yes <input type="checkbox"/> No <input type="checkbox"/>
Communication requirement: hard of hearing <input type="checkbox"/> requires a translator <input type="checkbox"/> language.....	
unable to use phone <input type="checkbox"/>	
Other, please state (e.g. enlarged print letters):	

The screening process may involve a telephone screen - can the patient engage in this? Yes
No If 'no' please state why:

Current location of patient if not at home:

Planned discharge date if an inpatient:

Registered GP Surgery & Address:

Consultant name and other professionals involved:

Reason for Referral *specific short term rehab goals (this must be completed for at least one discipline or else referral will be returned)*

Physiotherapy:

Occupational Therapy:

Speech and Language Therapy:

Neuro Psychology:

Neurological Diagnosis and Date of Onset:

Scan/ investigation results:

Past Medical History:



www.berkshirehealthcare.nhs.uk

#NoExcuse ForAbuse

We will be polite and kind and we expect you to treat our staff in the same way. We will take action against anyone who is verbally, racially, physically or sexually abusive, including stopping access to our services.

Recent Rehab History and Present Functional Ability e.g. related to communication, mobility, daily living tasks, care needs. Please include location of inpatient therapy or community teams previously involved

Known risks (please state): either to patient e.g. falls risk, carer breakdown, employment, swallowing, mental health Or to health professionals visiting the home e.g. dogs

Referrer Details:

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



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