For hospital referral affix patient label here

**CSA / RTW Referral Form:**

**Community Stroke Advisor and Return to Work Advisor Service**

|  |  |  |  |
| --- | --- | --- | --- |
| Please return to:  Address: Stroke Foundation, 95-99 Molesworth Street, Thorndon Rise Building Level 1, Wellington 6011  Email: strokenz@stroke.org.nz  To discuss CSA or RTW referral by phone: 04 472 80 99 | | | |
|  | | | |
| REFERRER DETAILS | | | |
| Date: |  | **Name of Referrer:** |  |
| Organisation: |  | **Contact Ph/Email:** |  |
| □ GP □ Inpatient Stroke Service □ NASC □ Rehabilitation Specialist □ Social Worker  □ Community Service □ Other – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Contact referrer before contacting client (safety concern/additional information) □ | | | |
|  | | | |
| CLIENT DETAILS (or as per hospital label) | | | |
| Family Name: |  | **First Name/s:** |  |
| Title: | □ Mr □ Mrs □ Miss □ Ms  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Gender:** | □ Male □ Female □ Gender Diverse |
| NHI Number: |  | **D.O.B** (dd/mm/yyyy) |  |
| Ethnicity: | □ Māori □ NZ European □ Pacific Island □ Asian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Home Address: |  | | |
| Home Phone: |  | **Mobile Phone:** |  |
| Email Address: |  | **GP/Practice:** |  |
| ADDITIONAL CLIENT CONTACT | | | |
| Alternative Contact / Carer: |  | **Relationship to Client:** |  |
| Contact Phone |  | **Contact Email** |  |
| REASON FOR REFERRAL | | | |
| CSA Service: □ RTW Service: □ | | | |
| *Details* | | | |
| DETAILS OF STROKE / RELEVANT MEDICAL HISTORY | | | |
| Date of Stroke: |  | **Type of Stroke:** | □ Haemorrhagic □ Ischaemic □ TIA |
| Discharge Date: |  | **Discharging To:** | □ Home □ Care □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Details* | | | |
| ADDITIONAL PATIENT INFORMATION / FAMILY SITUATION | | | |
|  | | | |
| Other information attached? □ No □ Yes – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | | | |
| EMPLOYMENT (RTW Referral Only) | | | |
| Is there a current employer holding open a job? No □ Yes □ | | | |
| If Yes, please give job title and employer name, address & contact details | | | |
| Is client on any Benefits? No □ Yes □ | | | |
| If Yes, which Benefit(s) | | | |
| Return to work support required: | | | |