**Community Stroke Advisor Service**

For hospital referral affix patient label here

**Referral Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Please return to: or Email: ------------@stroke.org.nz  Stroke Foundation or Fax: Fax Number  Regional CSA Address [To discuss referral with CSA phone: XXXXXX] | | | | | | | |
|  | | | | | | | |
| REFERRER DETAILS | | | | | | | |
| Date: | |  | | | **Name of Referrer:** |  | |
| Organisation: | |  | | | **Contact Ph/Email:** |  | |
| □ GP □ Inpatient Stroke Service □ NASC □ Rehabilitation Specialist □ Social Worker  □ Community Service □ Other – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  | | | | | | | |
| CLIENT DETAILS (or as per hospital label) | | | | | | | |
| Family Name: | |  | | | **First Name:** |  | |
| Title: | | □ Mr □ Mrs □ Miss □ Ms  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Gender:** | □ Male □ Female □ Transgender | |
| NHI Number: | |  | | | **D.O.B** (dd/mm/yyyy) |  | |
| Ethnicity: | | □ Māori □ NZ European □ Pacific Island □ Asian □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Home Address: | |  | | | | **Client Email Address:** | |
|  | |
| Home Phone: | |  | | | **Mobile Phone:** |  | |
| Date of Stroke: | |  | | | **Type of Stroke:** | □ Haemorrhagic □ Ischaemic □ TIA | |
| Discharge Date: | |  | | | **Discharging To:** | □ Home □ Care □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Client consent for referral and additional information supplied? □ Yes □ No | | | | | | | |
| REASON FOR REFERRAL | | | | | | | |
|  | | | | | | | |
| DETAILS OF STROKE / RELEVANT MEDICAL HISTORY | | | | | | | |
|  | | | | | | | |
| ADDITIONAL PATIENT INFORMATION / FAMILY SITUATION | | | | | | | |
|  | | | | | | | |
| Discharge summary attached? □ Yes □ No | | | | **Other information attached?** □ Yes - specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No | | | |
| ADDITIONAL CLIENT CONTACTS | | | | | | | |
| Alternative Contact / Carer: |  | | **Relationship to Client**: | |  | **Contact Phone:** |  |
| GP/Practice: |  | | | | **GP Phone:** |  | |
| **GP Email:** |  | |

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