**Community Stroke Advisor Service**

For hospital referral affix patient label here

**Referral Form**

|  |
| --- |
| Please return to: or Email: ------------@stroke.org.nzStroke Foundation or Fax: Fax NumberRegional 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:** |  |

Version Date: 18 June 18