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 6011Email: strokenz@stroke.org.nzTo 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: |