**COMMUNITY NEUROLOGICAL REHABILITATION TEAM TRIAGE REFERRAL FORM**

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| **PATIENT** NAME:DATE OF BIRTH: AGE:NHS NUMBER:ADDRESS & POSTCODE :TELEPHONE NUMBER: | **REFERRER** NAME:OCCUPATION:SERVICE:DATE OF REFERRAL:ADDRESS & POSTCODE:TELEPHONE NUMBER: |
| **GP NAME**:ADDRESS/Postcode:TELEPHONE NUMBER:\*CCG:  | **NEXT OF KIN**:RELATIONSHIP:ADDRESS:TELEPHONE NUMBER: |
| **HOME SITUATION**: | **DIAGNOSIS/DATE OF EVENT**:**DISCHARGE DATE:** |
| **CURRENT SERVICE INVOLVED** – Name & Tel no.Social Worker:Community OT:District Nurse:Consultants:Occupational Therapist:Physiotherapist:S.A.L.T:Psychology:Care Agency/Day Centre: | **PRESENTING PROBLEMS**:12345Please enclose any other helpful information e.g. discharge reports, UL pathway form |
| **ANY RISKS WE SHOULD BE AWARE OF?** | **ANTICIPATED OUTCOME OF THE REFERRAL?**  |
| **DOES THE CLIENT REQUIRE AN INTERPRETER?** YES / NOIf so what language……………….. | **DO YOU CONSIDER THIS REFERRAL URGENT?** YES / NO**IS THE PATIENT AWARE OF THIS REFFERAL?** YES / NO |
| **SETTING FOR PHYSIO INPUT:*** Community
* Outpatient- Is transport required Y/N
 | **FIRST CONTACT FOR ARRANGING APPOINTMENT?*** Patient
* NOK Other …………………
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| **For Further Advice, Please Contact Us On**: Tel No : 0300 123 5007 Community Neurological Rehabilitation Team, Western Community Hospital, William Macleod Way, Millbrook, SO16 4XE |