**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**:  1  2  3  4  5  Please 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 / NO  If 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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| **If Not Using SystmOne:** Please send this form to  [SNHS.CNRT@nhs.net](mailto:SNHS.CNRT@nhs.net) | |
| **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 | |