First Community Health and Care

NHS

REFERRAL FOR 6 MONTH & ANNUALSTROKE REVIEW SERVICE. Phone: 01883-733891.	Please send forms **TOGETHER WITH STROKE HOSPITAL DISCHARGE SUMMARY** to: Oxted Therapies Unit, Barnetts Way, Oxted, Surrey. RH8 0NQ. FAX: 01883-733899.

(PLEASE COMPLETE ALL SECTIONS)

Patient Name		**DOB**		**Date of Referral**	
NHS Number		**Ethnicity**			
Address: **Post Code:** **Tel. Home:**		**G.P. Name:** **Surgery Address:** **Tel. No.:**			
Reason for referral: (please indicate by ticking box) **Six month review ☐** **Annual review ☐**					
Stroke Diagnosis: **Date of stroke:**					
Stroke Consultant:					
Stroke Treatment: (*ie.Thrombolysed?/ carotid endarterectomy/therapy inputs*)					
Other relevant Medical History ***(current and past)*:**					
Medication:					
ALERTS ? ***(e.g. safeguarding, allergies, risks to lone workers)*:**					
Social Situation ***(e.g. accommodation, access, POC, professionals involved)*:**					
REFERRER DETAILS	**NAME:**		**PROFESSION:**		
Signature:		**Place of Work:** **Contact Details:**			

For Office use only

Date Received:		
Date put on stroke register:		
Is this patient in SSNAP cohort?	Yes ☐	NO ☐
Date appointment offered:		