

**Email referral to** **bnssg.bristolafterstroke@nhs.net** **or** **office@bristolafterstroke.org.uk**

**Telephone us on 0117 964 7657 or post to The Gatehouse Centre, Hareclive Road, BS13**

**Stroke Support Referral Form**

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| REFERRER DETAILS |
| Referral Date |  | Organisation |  |
| Your name & role |  |
| Contact Number |  | Email Address |  |
| **CLIENT DETAILS** |
| NAME |  | Date of Birth |  |
| ADDRESS inc postcode |  |
| Contact Number |  | **NHS No** |  |
| EMAIL ADDRESS |  |
| GP Details |  |
| Gender |  | Ethnicity |  |
| EMPLOYMENT |  |
| **REASONS FOR REFERRAL** |  |
| **Any known risks for staff?** |  |
| Next of kin details |
| Next of kin/Carer Name |  | Relationship |  |
| Address inc Postcode |  |
| Telephone |  | Email |  |
| **CLIENT INFORMATION/SITUATION** |
| **DATE OF STROKE** |  | **DISCHARGE DATE** |  |
| **Name of community team discharged to?** |  |
|  **Brief Summary of client situation (include speech/reading, mood, mobility, vision/hearing)****Does the person have Aphasia? Yes / No** |
| What is best mode of contact? | Phone, text, letter, video whattsap, other |
| Is a communication professional required at appointments? | If yes, which type? |
| CONSENT |
| Consent Given for referral? **Yes / No** | Consent given to talk to carer/family member? **Yes / No** |