

**Email referral to** [**bnssg.bristolafterstroke@nhs.net**](mailto:bnssg.bristolafterstroke@nhs.net) **or** [**office@bristolafterstroke.org.uk**](mailto:office@bristolafterstroke.org.uk)

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

**Stroke Support Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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** | | | | | | | | | | | | |