Berkshire Healthcare
NHS Foundation Trust

Community based neuro-rehab (CBNRT) team referral form

Please ensure client being referred is medically stable **IMPORTANT: client must meet criteria (shaded boxes) before completing the referral** **This form must be completed in full and clear. Incomplete forms will be returned to sender**

	Yes
The client must be registered to a **Berkshire West GP to** receive this service	☐
Does the client have a **complex neurological condition?**	☐
Does the client have **impaired physical, cognitive and/or communication function**?	☐
Does client have **short term rehab potential**?	☐
Has the client **consented** to the referral? Please inform them that the referral will be screened prior to acceptance.	☐
The screening process may involve a telephone screen – can the patient engage in this? If 'no' please state why:	

Patient's Details

NHS No:	Date of Birth:
Title:	Ethnicity:
Forename(s):	Surname:
Address: Postcode:	Next of Kin name for contact: Should this be the main contact for the patient? ☐ Please state reason why: Relationship:
Telephone No: Consent to leave message:	Telephone No: Consent to leave message:
Communication requirement: e.g. hard of hearing☐ requires a translator☐ unable to use phone☐ Other, please state (e.g. enlarged print letters): ……..	
Current location of patient:	
Planned discharge date:	

Medical History:

Diagnosis: **Date of onset**: **Scan/ investigation results**:	**Past Medical History**:
Medication:	**Rehab to date:**
Social History: ***Please include details of accommodation, carer support, risk factors e.g. dogs, visit in pairs****	
Present Functional Ability: ***e.g. related to communication, mobility, daily living tasks, care needs***	
Disciplines/services currently/recently involved:	
Known risks (please state):	

Reason for referral and specific short term rehab goals / outcomes:

NB: *Equipment required i.e. rails/orthotics must addressed prior to referral being made to CBNRT*

Please ask the individual and all team members involved for their goals

Please attach any relevant reports

Disciplines Required:

Occupational Therapy☐ Physio☐ Speech and language☐ Neuropsychology☐

Doctor's Details:

Registered GP Surgery & Address:	Consultant name and other professionals involved:

Referrer Details:

Name:	Profession:
Address:	Telephone:
	Date:
Postcode:	

Return completed form to:

BHFT Referral Hub	**Tel: 0300 365 1234** **Email: Integratedhub@berkshire.nhs.uk**

CBNRT Admin Contact **01635 273303**