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| **Oxfordshire Early Supported Discharge for Stroke Referral Form** | | | | | | | |
| Patient Name:  NHS Number:  DOB:  Address:  Phone number(s): | | | | | GP name:  Practice:  Address:  Phone number: | | |
| **CPR status:** CPR / DNACPR  If it is a unified DNACPR – **please ensure patient has a copy before discharge** | | | | | | | |
| Next of Kin:  Relationship to the patient:  Phone number: | | | | | Other contacts: | | |
| **History of admission including date of stroke:** | | | | | | | |
| **Stroke type and symptoms:** | | | | | **Cause of stroke:** | | |
| **Has this patient been discussed/seen by the stroke team? Yes / No** | | | | | | | |
| **Past medical history:** | | | | | | | |
| **Why are you referring to ESD?** e.g. Which disciplines will be required to provide input? Details of specific rehabilitation required. | | | | | | | |
| **Criteria** | **Yes** | | **No** | **Comments** | | | |
| Do the patient and family know you are making this referral to ESD? |  | |  |  | | | |
| Confirmed diagnosis of new stroke |  | |  | CT result and date: | | | |
| **Is the patient medically fit to go home?** |  | |  | Predicted discharge date:  **Please send a medical discharge summary at point of discharge.** | | | |
| Is the patient continent? |  | |  | If no, how is it managed? Have you referred to the continence or district nurses for management after discharge? | | | |
| **Is the patient managing eating and/or drinking?** |  | |  | Specify any modified diet or interventions: | | | |
| **MUST Score:**  **Date:** |  | |  | If >2 please send a copy of the latest MUST score with this referral. | | | |
| **Does the patient have any difficulties with communication?** |  | |  | Please state specific problems here:  Please send a Speech and Language discharge summary if follow-up is required. | | | |
| **Is the patient able to manage their own medications?** |  | |  | Specify if any system required? | | | |
| **Are there any other nursing needs? e.g. pressure sores** |  | |  | Please specify: | | | |
| **Does the patient live alone?** |  | |  | If no, specify who with? | | | |
| **Do they have anyone that can support with shopping, laundry, cooking and cleaning etc?** |  | |  | Please add details: | | | |
| **Does the patient require care visits?** |  | |  | Details of support required:  Date care requested: | | | |
| **Did they have any pre-admission social support?** |  | |  | If yes, briefly specify what help they had, who provided it and when. | | | |
| **Which Cognitive Screen has been completed?** | Cognitive screen:  Date completed:  Outcomeresults/impairments: | | | | | | |
| **Have you noticed any concerns regarding the patient’s cognition, perception or memory?** |  | |  | If yes, please give details: | | | |
| **Have any functional assessments been completed?** |  | |  | Results: | | | |
| **Has a vision screen been completed?** |  | |  | Results and onward referrals completed: | | | |
| **Has the patient been screened or assessed for mood disorders?** |  | |  | If yes, please give details of any assessments: | | | |
| **Has a home assessment been completed?** |  | |  | If yes, give date of access/ home visit and brief summary of outcome or send a copy of the home visit report with this referral.  If no, does a visit need to be completed?  A member of the ESD team may be able to assist with this visit. Please contact the team to make arrangements. | | | |
| **Are there any safety concerns, risks or other considerations the ESD team should be aware of?** |  | |  |  | | | |
| **Current mobility including equipment using:** | | | | | | | |
| **Ability on stairs:** | | | | | | | |
| **Goals:** Please state at least one goal for each discipline required. Set by the MDT. | | | | | | **Provisional timescale:** | |
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| **Outcome measures (e.g.) 9HPT, Berg, TUAG** | | **Score:** | | | | | **Date:** |
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| **Name of referrer and designation: Date:**  **Telephone Number:**  **Ward: Consultant:** | | | | | | | |

Please **EMAIL** the completed form and additional information to [oxford.esd@ouh.nhs.uk](mailto:oxford.esd@ouh.nhs.uk)

**(Please note that this is a new email address as of May 2024).**

Please contact ESD team on **01865 572723** (ESD Office) to confirm receipt of the referral.

For referral criteria and ESD leaflet please see our [webpage.](https://www.ouh.nhs.uk/services/referrals/esd-stroke/)