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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 / DNACPRIf 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

**(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/)