

PATIENT DETAILS OR INSERT MEDICAL RECORD STICKER HERE

First Name:

Surname:

Address:

Postcode:

Suburb:

Date of Birth:

Patient Phone Number:

NOK contact details:

Medicare Number/Expiry Date:

General Practitioner:

Referrer contact details:

Date of Stroke:

Type of Stroke/TIA:

At time of referral:

Mobility aid:

walker

walking stick

other:

Mobility level of assistance:

independent

standby assist

other:

Communication status:

needs assistance

no assistance needed

Cognitive status

impaired

not impaired

Reason for Referral: (tick all that apply for patient)

Master Stroke (secondary stroke prevention for stroke patients)

SLAM-TIA (secondary stroke prevention for TIA/mini stroke patients)

Brainstorm (low mood post stroke)

Community Aphasia Group (communication difficulty post stroke)

Vitality (post stroke fatigue)

For community participation: Please encourage the client to contact the Stroke Recovery Association for support to connect with their local stroke support group: 1300 650 594.

Please send completed form to Referral and Information Centre on:

Fax: 4924 2502

Phone: 4924 2590

Email: HNELHD-CNRIC@health.nsw.gov.au