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| --- | --- | --- |
| **Patient details** |  | **Referrer details** |
| Name: |  | Name: |
| CHI: |
| Address: |  | Contact details |
| Telephone No: |  | Profession: |
| Consent to leave message □ |  | Date of referral: |
| **Clinical details** |  |  |
| Diagnosis *(include date of onset):* |  | Relevant medical history: |
| Mobility and dexterity :  *(transfers; aids; equipment; risk of falls, etc)* |  | Cognition, behaviours or emotions: |
| Level of independence:  *(personal care skills; domestic skills; ability to go out accompanied/alone)* |  | Relevant social history:  *(please include work status)* |
| **Referral information** |  |  |
| Request for service and why |  | Details of any other agencies involved: |
| Patient-centred goals for therapy *(please consider activity and participation and not impairment level goals):* |  | **If hospital inpatient:**  Hospital: Ward:  Hospital Consultant:  Discharge date: |
| Patient aware of referral □ |  |  |

**Please return completed form to:** [**loth.neurorehaboutpatientservice@nhs.scot**](mailto:loth.neurorehaboutpatientservice@nhs.scot)