|  |  |  |
| --- | --- | --- |
| **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**