Community Stroke Navigator Referral Form

For hospital referral affix patient label here

Please return to:	or **Email:**	or **to discuss by phone:**
Stroke Foundation, PO Box 12-482 Thorndon, Wellington	help@stroke.org.nz	0800 STROKE (0800 78 76 53)

REFERRER DETAILS			
Date:		**Name of Referrer:**	
Organisation:		**Contact Ph/Email:**	
☐ GP ☐ Inpatient Stroke Service ☐ NASC ☐ Rehabilitation Specialist ☐ Social Worker ☐ Community Service ☐ Other – specify: _____			

CLIENT DETAILS (or as per hospital label)			
Family Name:		**First Name/s:**	
Title:	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: _____	**Gender:**	☐ Male ☐ Female ☐ Gender Diverse
NHI Number:		**D.O.B** (dd/mm/yyyy)	
Ethnicity:	☐ Māori ☐ NZ European ☐ Pacific Island ☐ Asian ☐ Other: _____		
Home Address:			
Home Phone:		**Mobile Phone:**	
Email Adress		**GP/Practice:**	
ADDITIONAL CLIENT CONTACTS			
Alternative Contact / Carer:		**Relationship to Client:**	
Contact Phone:		**Contact Email:**	
DETAILS OF STROKE / RELEVANT MEDICAL HISTORY			
Date of Stroke:		**Type of Stroke:**	☐ Haemorrhagic ☐ Ischaemic ☐ TIA
Discharge Date:		**Discharging To:**	☐ Home ☐ Care ☐ Other: _____
Details			

REASON FOR REFERRAL (please comment based on referral criteria below)

- *are not currently enrolled with a general practice or other health provider.*
- *are likely to have difficultly receiving support/poor outcomes due to access barriers or the complexity of their condition.*
- *are living in a location where support services are limited.*

ADDITIONAL INFORMATION / FAMILY SITUATION / SAFETY CONSIDERATIONS / ESOL

Discharge summary attached? ☐ Yes ☐ No	**Other information attached?** ☐ Yes - specify: _____ ☐ No