

**STROKE REHABILITATION TEAM
BAGGOT STREET COMMUNITY HOSPITAL
REFERRAL FORM**

NAME: _____ **D.O.B.** _____

ADDRESS: _____ **GENDER** _____

TELEPHONE NO. _____

MOBILE: _____

G.P. _____ **G.P. TELEPHONE NO.** _____

ADDRESS: _____

PREVIOUS MEDICAL HISTORY

STROKE DATE/S

HOSPITAL/S ATTENDED FOR STROKE

CONSULTANT _____

C.T. BRAIN / MRI RESULTS

**REHABILITATION RECEIVED (E.G. PHYSIOTHERAPY, SPEECH AND LANGUAGE THERAPY,
OCCUPATIONAL THERAPY)**

PRESENT DISABILITY AND LEVEL OF INDEPENDENCE

CURRENT SERVICES INVOLVED (E.G. DAY HOSPITAL, DAY CENTRE, OTHER COMMUNITY SERVICES, VOLUNTARY SERVICES)

CURRENT MEDICATIONS

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HAVE YOU DISCUSSED THIS REFERRAL WITH YOUR PATIENT? YES _____ NO _____

SIGNATURE (CONSULTANT ___ GP___)

PRINT NAME

DATE

***Please enclose relevant Therapy and any relevant Medical reports ***

Return to:

**Stroke Rehabilitation Team
Baggot Street Community Hospital
18 Upper Baggot Street
Dublin 4
Ph: (01) 6699373
Fax: (01) 6607982
www.strokerehabunit.ie**