|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient Information | | | | | | |
| First Name |  | | Last Name | | | |
| Date of Birth |  | | | | | |
| Address |  | | | | | |
| Postcode |  | | | | | |
| Phone |  | | Alt Phone | |  | |
| Email |  | | | | | |
|  | | | | | | |
|  | | | | | | |
| Secondary Contact Person | | | | | | |
| First Name |  | | | | | |
| Last Name |  | | | | | |
| Phone |  | | Relationship | |  | |
| Email |  | | |  | | |
|  | | | | | | |
| Diagnosis | | | | | | |
| Date of Diagnosis | |  | | | |
| Diagnosis | |  | | | |
|  | |  | | | |
| Previous medical history | |  | | | |
|  | |  | | | |
| Communication | | | | | | |
| Communication difficulties | | Yes/No (If yes, describe) | | | |
| Is English a second language? | | Yes/No (If yes, list preferred language) | | | |
| Is an interpreter required? | | Yes/No | | | |
|  | |  | | | |
| Reason for Referral | | | | | | |
|  | | | | | |
|  | | | | | |
|  | | | | | |
| Referrer Details (if relevant) | | | | | | |
| Name | |  | | | |
| Organisation/position | |  | | | |
| Phone/email | |  | | | |
| Relevant information | |  | | | |
|  | |  | | | |
| Rehabilitation Goals | | | | | | |
| Cognitive | |  | | | |
| Upper limb - movement | |  | | | |
| Upper limb – sensory | |  | | | |
| Support/adjustment | |  | | | |
| Life skills/activities | |  | | | |
| Social | | | | | | |
| Primary supports (Family, friends, services) | |  | | | |
| Living situation | |  | | | |

|  |  |
| --- | --- |
| Consent | |
| This information is true and correct and I consent to Astralis Stroke Occupational Therapy contacting me prior to acceptance and provision of services.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |