SAV REFERRAL FORM

Referral Date: _____

REFERRER DETAILS			
Referrer First Name:		Referrer Surname:	
Referrer Position:			
Organisation:			
Patient/Client Referral Consent: ☐ Yes ☐ No **(Please tick one box)**			
STROKE SURVIVOR DETAILS			
First Name:		Surname:	
Address:			
Home Phone:		Mobile:	
Email Address:			
Male / Female / Other **(Please circle)**	Pronoun:	Age:	Date of Stroke: **(dd/mm/yyyy)**

Reason for Referral: **(Please tick - multiple boxes can be selected)**

☐ Peer Support & Social Engagement

☐ Skill Development & Assisted Activities - person-centred support to develop new and/or existing skills, and access a range of all abilities activities

☐ Vocation Support - case management support to engage in employment (paid/voluntary and/or education (further studies)

Suggested Strategies/Additional Information:
Please provide any details that will assist us to prepare for an initial consultation with your patient/client.

ALTERNATE / EMERGENCY CONTACT (Carer/ Partner/ Family Member/ Support Worker)	
First Name:	Surname:
Home Phone:	Mobile:
Email Address:	

ADDITIONAL INFORMATION	
Language/s at Home: English / Other: _____ **(Please circle and specify if 'Other')**	Does your patient/client have their own transport? Yes / No **(Please circle)**

SUPPORT NEEDS SCALE

On a scale of one to ten, please circle the most applicable score in terms of support required.

Mobility: **(1 = low need / 10 = high need)**

1	2	3	4	5	6	7	8	9	10

Speech: **(1 = low need / 10 = high need)**

1	2	3	4	5	6	7	8	9	10

Emotional: **(1 = low need / 10 = high need)**

1	2	3	4	5	6	7	8	9	10

Interpreter: **(1 = low need / 10 = high need)**

1	2	3	4	5	6	7	8	9	10

Patient/client's current mood: (e.g. happy, anxious, sad / low mood)

Additional Comments: (Transport requirements, support needs scale & current mood)

I have been informed of the Stroke Association of Victoria and the support that's available to stroke survivors & carers. As a result, I agree to this referral and give consent for my information to be shared with the Stroke Association of Victoria.

Stroke Survivor's Signature:

Stroke Survivor's Full Name: _____
Date: _____

(The above may be signed by the Stroke Survivor's Carer/Partner on their behalf - please ensure you make a note if this is the case.)

Referrer's Signature:

Referrer's Full Name: _____
Date: _____

Please email this completed referral form to referrals@strokeassociation.com.au

The Centre Coordinator or Vocation Consultant for your region will acknowledge their receipt of this completed referral form and may be in touch with you for further information about your patient/client.