STROKE
ASSOCIATION of VICTORIA

BALLARAT STROKE SUPPORT CENTRE (SSSC) – REFERRAL FORM

Date: _____

REFERRER DETAILS		
Referrer First Name:	Referrer Surname:	
Referrer Position:		
Organisation:		
Patient agreed to referral **(please tick)** ☐ Yes ☐ No		
CLIENT/STROKE SURVIVOR DETAILS		
First Name:	Surname:	
Address:		
Home phone:	Mobile:	
Email address:		
DOB:	Age:	Male / Female (Pls circle)
Reason for Referral:		
Suggested Strategies / Comments:		

For clients/stroke survivors with communication (Aphasia), and/or mobility difficulties, please complete the below information.

PREFERRED CONTACT DETAILS (Carer/Partner/Family Member)	
First Name:	Surname:
Home phone:	Mobile:
Email address:	

Please list any strategies required to help with communication.
(e.g. Repetitive speech, gestures, communication book or electronic devices)

Please list any mobility requirements (e.g. walking aids, wheelchair access, electric scooter)

Any other relevant information (e.g. Interests/Hobbies/Social or Cultural Preferences)

Please email the completed referral to Veronica Hayes - Centre Coordinator
Email: ballarat@strokeassociation.com.au
Phone: 0402 200 397