

**BENDIGO STROKE SUPPORT CENTRE (BSSC) – REFERRAL FORM**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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: |

Please email the completed referral to Tamara Lalor - Centre Coordinator

Email: bendigo@strokeassociation.com.au

Phone: 0490 709 962

**For client/stroke survivor with communication (Aphasia), and/or mobility difficulties, please complete the below information.**

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| **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)

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

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

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