

**NEWPORT STROKE SUPPORT CENTRE (NSSC) – 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 Hazy-Mars Connelly - Centre Coordinator

Email: Newpot@strokeassociation.com.au

Phone: 0434275295

**For client/stroke survivor 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)

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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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