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**REFERRAL FORM FOR ISLINGTON COMMUNITY NEURO-REHAB TEAM OR REACH**

**Please email form to:** **rapidaccess@islington.gov.uk** **Rapid Access admin: Tel: 0207 527 2179**

**(can be contacted for referral queries)**

**Please consider the following alternative services before referring to CNRT or REACH:**

1. Musculoskeletal physiotherapy – please refer via central bookings (arti.centralbooking@nhs.net)if client is able to leave their house for a physiotherapy appointment (including with transport)
2. Falls medical clinic – please refer to consultant via GP.
3. ICAT – For clients over 75 years old who require a comprehensive geriatric MDT assessment, please refer via email: [whh-tr.ICAT@nhs.net](file:///C%3A%5CUsers%5CCarole.MacGregor%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5C0UWV3YX6%5Cwhh-tr.ICAT%40nhs.net)
4. Occupational Therapy Social Services for equipment provision and major adaptations -please refer via Access and Advice **Tel**: 020 7527 2299 **Email**: **[Islington Adult Social Care Request for Service Form](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fforms.office.com%2FPages%2FResponsePage.aspx%3Fid%3DI6ITVb5600KxYcBqvFHLLlTmjyJ3UcBIq59GQpZDoJlUNUUyMjRNQ1g4V1VKUkFMWlNYMDc1NDNWOCQlQCN0PWcu&data=05%7C01%7Ccarolemacgregor%40nhs.net%7C9fd1eb7ffb9849ca591408db5d102209%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638206096093204231%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=xgAPIVQawTUp43DzoiHGKE5J4sXhNyYlG8OZCum0geE%3D&reserved=0)**

**Please indicate whether you require Community Neuro-Rehab or REACH, then choose the discipline/service(s) you require.**

**Islington REACH Team**For Islington residents with non-neurological conditions who are unable to access community services

Physiotherapy □
Occupational therapy □
Speech and Language Therapy □
(if referring from a care home, please
include Swallow Screen)
**Falls assessment □**Mobility/gait/stairs assessment □
Environmental □
Improving independence and confidence within the home and community □

**Community Neuro-Rehabilitation Team**

For people with neurological conditions, including stroke, MS, TBI.

Neuropsychology □
Occupational therapy □
Physiotherapy □
Speech and Language Therapy □
(if referring from a care home, please
include Swallow Screen)
MS Practitioner □

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| **GP Details** |
| Practice: | GP Name: |
| Tel: |
| **Referrer’s Details** |
| GP: [ ] Yes  [ ] No | Relationship to client: |
| Team/service name  | Tel:Email:  |
| **Client Details** |
| Title |  | DOB |  |
| First name  |  | NHS no |  |
| Surname |  | Gender |  |
| Address |  | Tel no. |  |
| Post code |  | Mobile no. |  |
| Is client able to grant access? | [ ] Yes [ ] No[ ] Key Safe[ ] Family/Carer | Next of Kin  | Name:Relationship:Tel: |
| Ethnicity |  | **Has client consented to referral?** |  |
| First Language |  | Interpreter Required? |  |
| **Medical History**  |
| Past Medical History/Diagnosis | Current Medication (Please list): |
| **Reason for referral**  |
| **What would the client like to achieve by working with us?****Has there been a recent change in the client’s baseline function?** If Yes, please give details:**Is the client on Reablement?** Yes [ ]  No [ ] **Are there any known risk to lone workers?** Property [ ]  Suicide/Self harm [ ]  Domestic violence [ ]  Harm to others / from others [ ]  Drug/alcohol abuse [ ]  Not considered a risk [ ]  Hoarding [ ]  Please give details:  |

**In order to avoid any necessary delays, please ensure that all sections of the form have been fully completed.**

Referrers signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_