**HASU/ASU to Inpatient Stroke Service (ASU/SRU) Transfer of Care Form V3
*Guidance Notes:*** *Please complete this summary transfer of care document for transfers from a* ***Regional HASU to inpatient stroke services (Acute Stroke Unit – ASU or Stroke Rehabilitation Unit – SRU) at another site*** *only.*

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| --- | --- |
| **PERSONAL DETAILS:** |  |
| Full Name: | NHS Number: |
| Date of Birth: | Next of Kin: |
| Address: | Preferred Contact Number: |
| Ethnicity: | Religion: |
| Date of Admission: | Date of Transfer: |
| **GP DETAILS:** |  |
| Address including postcode: | Telephone no: |
| **Referral Details:** |
| Name of Consultant/referrer: |
| Has patient consent been gained for the referral? YES / NO |
| Does the patient have capacity to consent? YES / NO |
| If the person does not have capacity, was the decision made in a best interest meeting? YES / NO |
| If no, give details: |
| DNACPR in place: YES /NO Date of issue: Review date: |
| Has the person tested positive for COVID-19? YES / NO Date tested: |
| Is the person a suspected case of COVID-19 ? YES / NO  |
| Is the person shielding ? YES / NO  |
| Is this person in self isolation ? YES / NO  |
| **Referral destination:** | **Service required ( Please indicate if high / medium or low priority- H/M/L)** | **Professions required:** |
| * Barnsley
 | * Acute Stroke Unit H/M/L/
 | * Clinical Psychology
 |
| * Bassetlaw
 | * Stroke Rehab Ward

H/M/L | * Dietetics
 |
| * Chesterfield
 | * Early Supported Discharge

H/M/L | * Medical
 |
| * Doncaster
 | * Community Stroke Team

H/M/L | * Nursing
 |
| * Rotherham
 | * Intermediate Care

H/M/L | * Occupational Therapy
 |
| * Sheffield
 | * 6/52 review

H/M/L | * Physiotherapy
 |
| * Other/OOA
 | * 6/12 review

H/M/L | * Speech & Language Therapy
 |
|  | * Other

H/M/L | * Social care
 |
|  |  | * Other
 |
| **MEDICAL HISTORY:** |
| **Date of Stroke:**Details of Stroke: (Thrombolysis / CT / MRI / Diagnosis) |
| Past Medical History:  |
| Current Medication:  |
| **Allergies or Sensitivities:** |
| Known Risks: (eg. Falls / Infection / Safeguarding Concerns) |
| Social History/Circumstances: |
| Other Services Involved and Onward Referrals to date: (eg. Social Care / Orthotics / Spasticity Clinic / Splinting / FES / Wheelchairs) |
| **PATIENT PRESENTATION:** |
| Medical Status:BP/Pulse: Skin Integrity/Waterlow Score: Infection status (MRSA, Clostridium Difficile, Loose stools): |
| Swallow:Aspirating YES/NO Please expand:Respiratory status: |
| Eating and Drinking: Enteral feeding: YES /NOMUST score:IDDSI Framework (Please delete as applicable)Fluids: 0 Thin (normal) 1 Slightly thick, 2 Mildly thick, 3 Moderately thick, 4 Extremely thickDiet: 7 Regular (normal), 6 Soft & bitesized, 5 Minced & moist, 4 Pureed, 3 Liquidised. |
| Communication:Receptive Dysphasia YES/NO Please expand:Expressive dysphasia YES/NO Please expand:Dysarthria YES/NO Please expand:Other: |
| Continence:Catheter YES/NO If YES state rationale for catheter in situ: |
| Physical Ability:Modified Rankin Score:Transfer ability:Mobility: |
| Functional Ability: Barthel Score:Assistance required for Wash/Dress/Toileting: |
| Cognition:MOCA score:OCS:Other: |
| Behaviour and Emotions:Mood score:Any special requirements (eg. 1:1, observations, visible bay, etc): |
| Sensory:Vision:Hearing:Touch/proprioception:Other: |
| Other: |
| IDENTIFIED PATIENT NEEDS / GOALS: |
| 1.2.3. |
| Secondary Prevention: |
| EQUIPMENT AND CARE PROVISION REQUIRED BEFORE TRANSFER: |
| Equipment in place: | Equipment outstanding: | Action/date: |
| REFERRER DETAILS: |
| Full Name: | Profession: |
| Contact Number/email: | Date/time of completion: |
| *Please attach any additional relevant information/documents.* |