**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.*

[*swy-tr.barnsleysrureferrals@nhs.net*](mailto:swy-tr.barnsleysrureferrals@nhs.net)

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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 /NO  MUST score:  IDDSI Framework (Please delete as applicable)  Fluids: 0 Thin (normal) 1 Slightly thick, 2 Mildly thick, 3 Moderately thick, 4 Extremely thick  Diet: 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.* | | | |