CENTRE FOR BRAIN RESEARCH
THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau

THE UNIVERSITY OF AUCKLAND
CLINICS

BRAIN RECOVERY CLINIC ASSESSMENT REFERRAL LETTER

Date of referral: ___/___/___

PATIENT DETAILS:

SURNAME:_____ **FIRST NAME:**_____

ADDRESS:_____ **DOB:**_____

_____ **NHI:**_____

_____ **PHONE NO:**_____

ALTERNATIVE CONTACT

SURNAME:_____ **FIRST NAME:**_____

PHONE NO:_____

RELATIONSHIP TO PATIENT:_____

GP details: (name, practice name, full contact address, contact phone and fax numbers)

SURNAME:_____ **FIRST NAME:**_____

PRACTICE NAME:_____

PRACTICE ADDRESS:_____

_____

_____

PHONE NO:_____ **FACSIMILE NO:**_____

REFERRAL SOURCE:

GP ☐ STROKE FOUNDATION ☐ Name of Field Officer_____

Other Specialist ☐ (Please specify _____)

DETAILS REGARDING STROKE: FUNCTIONAL EFFECTS AT THE TIME OF THE STROKE

DATE:_____
(of stroke this information refers to)

STROKE: 1. Non-traumatic NO / YES **2. Traumatic** NO / YES
(Circle that which applies)

FUNCTIONAL EFFECTS: (Circle that which applies)

SPEECH: Difficulties: NO / YES (if yes explain)_____

SWALLOWING: Difficulties: NO / YES (if yes explain)_____

PHYSICAL LIMITATION:

1. UPPER LIMBS: Right side difficulties: NO / YES (if yes explain)_____

Left side difficulties: NO / YES (if yes explain)_____

2. LOWER LIMBS: Right side difficulties: NO / YES (if yes explain)_____

Left side difficulties: NO / YES (if yes explain)_____

3. VISION LOSS: NO / YES (if yes explain)_____

4. HEARING LOSS: NO / YES (if yes explain _____

RELEVANT MEDICAL HISTORY: (attach discharge and clinic letters if available)

1. Pre Stroke Medical History:

2. Post Stroke Medical History:

CURRENT CLINICAL / FUNCTIONAL ISSUES:
(Please place a tick in the domain box if this is currently causing some concern, and give an explanation / (description. If not a current concern please put a cross in the domain box or n/a in the description line)

☐ Cognition (e.g. memory, understanding)_____

_____

☐ Mood_____

_____

☐ Speech (e.g. slurred, slow, word mixing)_____

_____

☐ Swallowing (e.g. choking, coughing)_____

_____

☐ Medication management 1. Self responsibility YES ☐ NO ☐

If NO who is responsible for giving medications_____

_____

☐ Manual dexterity (e.g. buttons, knife and fork use, brushing hair/teeth)_____

_____

☐ Mobility (e.g. walking with stick, walker,1 or more people to help, distance)_____

_____

☐ Pain (are you experiencing any pain, if Yes, explain)_____

_____

☐ Home safety (e.g. falls, seizures)_____

_____

☐ Vision_____

_____

☐ Continence_____

_____

☐ Need for community resources (e.g. home help, showering)_____

_____

☐ Caregiver / Family stress_____

_____

Other (please specify)_____

_____

CURRENT MEDICATIONS: (Please list all current medications being taken by patient and enclose a copy of a current medication list/recent prescription if available.)

Medication Name	Medication Dose (e.g. milligrams, puffs,)	Time medication taken (e.g. morning, afternoon, night)

Known Allergies to medications YES ☐ NO ☐

If yes list _____

Other Known Allergies (e.g. foods) YES ☐ NO ☐

If yes list _____

Smoking History: Current smoker: Yes ☐ Average Cigarettes/day_____ Age started(yrs)_____

Ex Smoker ☐ Average Cigarettes/day _____ Age started(yrs)_____ Age Stopped(yrs)_____

Life long non Smoker ☐

Alcohol (units/week): _____

SOCIAL CIRCUMSTANCES: (e.g. housing type, living arrangement (managed care, own home, etc), employment, etc)

Home Help Yes ☐ No ☐
If yes explain type and quantity of help given_____

PERTINENT INVESTIGATIONS:
(Attach report to this form. If report is unavailable please give hospital details and dates of test if known)

Has the patient had a previous CT/MRI Brain? Yes ☐ No ☐

Has the patient had a previous Carotid Doppler? Yes ☐ No ☐

Has the patient had a previous echocardiogram? Yes ☐ No ☐

Please attach copy of report if available

ANY SPECIFIC QUESTIONS? (that the patient would like to be addressed at time of the clinic assessment)

REFERRAL SOURCE DETAILS: (name, full contact address, contact phone and fax numbers)

SURNAME:_____ **FIRST NAME:**_____

WORK TITLE:_____

ORGANISATION ADDRESS:_____

_____

PHONE NO:_____ **FACSIMILE NO:**_____

CLINICAL RECORDS

Does the patient consent for us to access their previous medical records? Yes ☐ No ☐

Patient consent (signed by patient or carer)

Name _____ **Signed** _____ **Date** _____

Referrer consent

Name _____ **Signed** _____ **Date** _____

General Practitioner

Name _____ **Signed** _____ **Date** _____

Please Post the form to: The University of Auckland Clinics
Brain Recovery Clinic
Private Bag 92019, Auckland 1142

Fax the form to: +64 9 303 5978

email the form to: brainrecovery@auckland.ac.nz

Please call us on +64 9 923 1831 if you have any questions or require more information.