

OUTPATIENT REFERRAL FORM



Please complete this form even if a separate referral letter has been sent. This will enable us to expedite the referral and ensure we offer the high level of service we aim to provide.

Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ

This form can be submitted by email or fax:

Telephone Enquiries: 01244 665330

Email: deniseujvari@stgeorgehealthcaregroup.co.uk

Fax: 01925 423307

OUTPATIENT SERVICE REQUIRED (PLEASE TICK ✓)

Electrophysiology	Electroencephalogram*		Visual Evoked Potential*		Motor Conduction Time*	
	Brainstem auditory evoked potential*I		Somatosensory Evoked Potential*		Carpal Tunnel Screen*	
	Cognitive Evoked Potential*					

Musculoskeletal	Physiotherapy*		Hydrotherapy		Spasticity management (including medical and postural management and Botulinum toxin)	
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Disorders of Consciousness	Sensory and cognitive electrophysiology, in addition to anatomical and functional brain imaging, provided as an outpatient service to care teams already undertaking formal behavioural assessment. Where this is unavailable locally, an inpatient multimodal service offering all these assessments, including behavioural testing, is available at St Cyril's.				
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Location	St Cyril's rehabilitation outpatient clinic		Mobile service at current address (available with *services only)	
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REFERRAL DETAILS

Patient's name			Date of Birth		
Address	Current Address		Home Address (if different)		
	Telephone		Telephone		
	Fax				
Referrers name			Designation		
Address	Referrers Contact Address		GP Address (if different)		
	Telephone		Telephone		
	Fax		Fax		

CLINICAL HISTORY

Diagnosis/Presentation	Date of onset	
Reason for referral / objective		
Previous medical history		
Drugs / Medication	Medication	Dose

MOBILITY (please tick v)

Walking	Indoors		Outdoors		Stairs		With Aid		Assistance Required	
Details						Distance (meters)				

Wheelchair	Attendant		Self Propelling		Powered	
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TRANSFERS (please tick v)

Bed to chair	Independent		Assistance of 1 person		Assistance of 2 persons	
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FUNDING DETAILS

Funding Contact Name						
Address for Invoice						
Telephone				Fax		

ANY OTHER RELEVANT INFORMATION

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