

Stroke Six Month Review: Summary Report

Name:			
D.O.B:		NHS number:	
Reviewed by:		Date of review:	

At your review your blood pressure was: _____ / _____

At your review we identified that you have some unmet needs in the following areas:

Medicine management	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Daily activities	<input type="checkbox"/>	Sleep pattern	<input type="checkbox"/>
Medicine compliance	<input type="checkbox"/>	Vision	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	Memory & concentration	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Falls	<input type="checkbox"/>	Driving	<input type="checkbox"/>
Anti-thrombotic therapy	<input type="checkbox"/>	Communication	<input type="checkbox"/>	Mood	<input type="checkbox"/>	Transport and travel	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	Swallowing	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Activities & hobbies	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	Emotionalism	<input type="checkbox"/>	Work	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	Weight management	<input type="checkbox"/>	Personality changes	<input type="checkbox"/>	Money & benefits	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	Pain	<input type="checkbox"/>	Sexual health	<input type="checkbox"/>	House & home	<input type="checkbox"/>
Healthy eating	<input type="checkbox"/>	Contenance	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Carer needs	<input type="checkbox"/>
Other:							

Summary of your unmet needs:

Actions for you (the stroke survivor):

Actions for us:

Actions for your GP practice:

A copy of this summary has been automatically sent to your GP (unless stated otherwise at your review)
For further information see www.nhs.net and enter a search term relating to your health conditions e.g. stroke.

For further information please contact: