Referral Form

Confidential

Person being referred *(see Contact Assessment for full details)*

Family name:	Forenames:
Preferred name/form of address:	Title:

NHS ID		SS ID	
Hosp ID		Other ID	

Gender *(tick)*	**Female**		**Male**		**Date of birth**	

Referral to	
Contact details of referrer	
Reason for referral *(including anticipated health and social care needs)*	

Does this require urgent attention? *(if yes state reasons below)*	**No**		**Yes**	

Person's expectation of referral	

Known risk(s) to self? *(e.g. falls, self-harm, if yes describe below)*	**No**		**Yes**	

Known risk(s) to others? *(if yes describe below)*	**No**		**Yes**	

Safety issues when visiting? *(if yes describe below)*	**No**		**Yes**	

Service user name:	ID number:

Medical background *(complete all details below)*				
Has the person had a recent illness, medical problem or hospital admission that is relevant to the current referral?	**No**		**Yes**	
Details of condition(s)/diagnoses/procedures/investigations				
Are there other physical or health difficulties relevant to the current referral? *(e.g. chronic illness, falls, functional/mobility problems, detail)*	**No**		**Yes**	
Current medication *(include mode of administration/difficulties in taking medication)*				
Other relevant information *(e.g. prognosis, current physical state)*				
Source of medical details:				
Supporting documentation				
Copy of contact assessment attached?	**No**		**Yes**	
Copies of other relevant reports attached? *(e.g. medical/social work)*	**No**		**Yes**	
List reports attached:				

Form completed by:	Designation:	
Signed:	Date:	Date sent:

Service user name:	ID number:

Name:	Main ID:	Completed by:

Basic Personal Information (BPI) Confidential

Family name:	Given name(s):
Prefers to be known as:	Title:
NHS No *(enter n/k if not known)*:	Social care No: *(enter n/k if not known)*:
National Insurance Number :	GP: (see Key Contacts (page 2) for full details)
Gender *(tick)* Female ☐ Male ☐	Date of birth
Present address/location: Post code: Tel number(s):	Permanent address (if different): Post code: Tel number(s):
Marital /Civic status:	Resident of:
Preferred language	Interpreter required? Yes ☐ No ☐

Ethnicity	White		Mixed		Asian or Asian British		
	White British	☐	White and Black Caribbean	☐	Indian	☐	
	White Irish	☐	White and Black African	☐	Pakistani	☐	
	Any other white background	☐	White and Asian	☐	Bangladeshi	☐	
	Black British	☐	Any other mixed	☐	Any other Asian	☐	
	Black Caribbean	☐	Other groups		Not stated	☐	
	Black African	☐	Chinese	☐	*Details of 'other' selections (enter category/code):*		
	Any other Black background	☐	Any other group *(specify)*	☐			
Religion	None	☐	Buddhist	☐	Jewish	☐	
	Christian	☐	Hindu	☐	Muslim	☐	
	Sikh	☐	Any other religion	☐	*Details:*		
Current/previous occupation							

Primary client category	Physical disability, frailty or sensory impairment	☐	Physical disability/frailty	☐	Hearing impairment	☐
			Visual impairment	☐	Dual sensory loss	☐
	Mental health	☐	Dementia	☐	Learning disability	☐
	Substance misuse	☐	Other vulnerable person	☐	*Details:*	

Home details

Is your accommodation	Temporary	☐	Permanent	☐	Homeless	☐		
Type of permanent accommodation	House	☐	Flat/bedsit	☐	Bed and breakfast	☐	Supported housing	☐
	Bungalow	☐	Nursing care	☐	Residential care	☐	Other (specify)	☐
Tenure- permanent accommodation	Council	☐	Home owner	☐	Private rented	☐	With family	☐
	Housing association			☐	Other *(specify)*	☐	*Details:*	
Does the home have a working smoke alarm?				Don't Know	☐	Yes ☐	No	☐

Service user name:	**ID number:**

Name:	Main ID:	Completed by:				
Does the home have Carelink? / Emergency Alarm?		Yes	☐	No	☐	
Does the home have any Telecare Devices?		Yes	☐	No	☐	Details:

Service user name:	**ID number:**

Name:	Main ID:	Completed by:

Key contacts	
Person most close to person *(e.g. carer/next of kin)*	**Emergency contact** *(if different)*
Family name:	Family name:
Forenames:	Forenames:
Preferred name:	Preferred name:
Relationship to person:	Relationship to person:
D.O.B.:	Address:
Ethnicity:	
Address:	
Post-code:	Post-code:
Phone number(s):	Phone number(s):
E-mail:	E-mail:
Availability:	Availability:
Referrer's details	**GP**
Name:	Name:
Role:	Practice:
Organisation:	Address:
Address:	
Post-code:	Post-code:
Phone number(s):	Phone number(s):
Fax number:	Fax number:
E-mail:	E-mail:
Care co-ordinator	**Hospital consultant**
Name:	Name:
Role:	Ward/specialty:
Organisation:	Organisation:
Phone number(s):	Phone number(s):
Fax number:	Fax number:
E-mail:	E-mail:
Lasting Power of Attorney (Personal Welfare)	**Lasting Power of Attorney (Property & Affairs)**
Name:	Name:
Role:	Role:
Organisation:	Organisation:
Address:	Address:

Service user name:	**ID number:**

Name:	Main ID:	Completed by:
Post-code:	Post-code:	
Phone number(s):	Phone number(s):	
Fax number:	Fax number:	
E-mail:	E-mail:	

Household details *(who lives with person)*	Number of people in household				
Does the person live alone? *(if no complete household details below)*	Yes	☐	No	☐
Details of household:				
Does the person have any caring roles? *(detail below, including primary carer)*	Yes	☐	No	☐
Is the person being cared for? *(detail below, including primary carer)*	Yes	☐	No	☐
Does the household contain a dependent child? *(detail below, including primary carer)*	Yes	☐	No	☐
Does the household contain a person over 18 being cared for?*(detail, inc. primary carer)*	Yes	☐	No	☐
Does the household contain any pets? *(detail below, including primary carer)*	Yes	☐	No	☐
Visit information *(access, when available, dog etc)*	Safety issues when visiting?	Yes	☐	No	☐
Key safe available?		Yes	☐	No	☐
Key holder name *(if any)*		Tel No			
Was consent given for information to be shared as needed (detail requested limitations below)		Yes	☐	No	☐
Signature of person:		Date:			
Assessments completed by :		Job Title:			
Signature:		Date:			