|  |
| --- |
| Community Therapy **Tel: 01752 434195 for PL1, PL2, PL5 (West) Tel: 01752 435346 for PL7, PL9 (East)** **Tel 01752 434171 for PL3, PL4 (South) Tel: 01752 435441 for PL5, PL6 (North)****Email:** **LIVEWELL.therapyreferrals@nhs.net** |
| Referral form will be returned if all sections are not completed and clear |
| **GP name and address:****GP tel. no:****Date last seen by GP *(if known)*:****Relative/Carer contact details:****Permission to contact the relative/carer:** | **Person’s name:****NHS no:****Date of birth:****Address *(include permanent address if temporary):*****Post Code:****Tel:** |
| **Referred by: Position:** **Tel. no: Location: Date of referral:** **Confirm person has consented and agreed to referral: Yes** **Patient lacks capacity and referral completed in best interest: Yes** **GP informed of referral? Yes / No *(essential if swallowing referral)*** |
| **Diagnosis/current history:** **Date of onset:****Relevant medical history:****Medication:**  |
| **What is the person’s perceived problem/need?** |
| **Reason for referral*****(referrer’s expectation, aim or goal of the intervention):*** |

|  |
| --- |
| **Previous therapy/treatment *(include dates and outcome if known):*** |
| **Please consider attaching the following additional information:****Drug chart****GP summary****Discharge summary****Goals and treatment plan *(essential if referring to a Therapy Support Worker)*****Health Needs Assessment** |
| **Is there a risk to staff visiting this person?** **Comments:****Visiting alone Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Environmental Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Access Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Infection Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Pets Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Smoking Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Other Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****If no/unknown please √**  |
| **Prioritising degree of urgency *(Please delete as appropriate*):****Would intervention help prevent a hospital or care home admission? Yes/No/Unknown****Would intervention facilitate discharge? Yes/No****Is the person medically able to participate? Yes/No****Is the person’s immediate safety compromised? Yes/No****Does the person live alone? Yes/No****Can the person travel to Mount Gould?*****(Please note that this should be ability to travel rather than patient choice)* Yes/No*****Comments regarding urgency:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Is the person willing for information gained during this episode of care to be shared with other agencies as appropriate? Yes / No** |

*Please complete this form electronically and email with relevant attachments to:* **LIVEWELL.therapyreferrals@nhs.net**