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| 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**](mailto: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):*** | |

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| **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**](mailto:LIVEWELL.therapyreferrals@nhs.net)