# Referral Form

**Referrer to complete all sections**

**Name:**

**Prefers to be known as:**

**Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Other** (state) ☐

**Does the person being referred have mental capacity to consent to referral?** **Yes** ☐ **No** ☐

**DNACPR in place?** **Yes** ☐ **No** ☐

**PPC in place?** **Yes** ☐ **No** ☐

**Patient/Client consent to referral** **Yes** ☐ **No** ☐

**Date:**

**Address:**

**Post Code:**

**Email:**

**Tel. No:** **Mobile:**

**OK to leave a message?** **Yes** ☐ **No** ☐

**Date of Birth:** **Age:**

**Gender**

**Male** ☐ **Female** ☐

**Other** (please give details)**:**

**Ethnic origin:**

**Religion:**

**Occupation**

**Employed** ☐ **Self Employed** ☐ **Retired** ☐

**Unwaged** ☐ **Other** (give details):

**N.I. No:**

**Marital Status:**

**Children** (names & ages)**:**

**Living Arrangements**

**Partner/Spouse** ☐ **Alone** ☐

**Relative** ☐ **Friend** ☐

**Warden Control Acc** ☐ **Nursing Home** ☐

**Notes re Access:**

**Next of Kin/Carer**

**Name:**

**Address:**

**Post Code:**

**Email:**

**Tel. No.** **Mobile:**

**Relationship to Patient/Client:**

**To be assessed:** **Yes** ☐ **No** ☐

**Allergies:**

**No** ☐ **Yes** ☐

**Details**:

**Referred by** (name/organisation):

**Contact No:**

**General Practitioner:**

**Practice:**

**Tel. No:**

**Patient/Client NHS Number:**

**Consultant:**

**Hospital:**

**Tel. No:**

**Other Professional Services involved**
(Please give name and contact no.)

**District Nurse:** **Occ. Therapist:**

**Mac. Nurse:** **Counsellor:**

**Physio:** **Other** (give details):

**Issues at referral:**

**1.**

**2.**

**3.**

**Date diagnosed:**

**Diagnosis:**

**Stage of disease & any metastatic spread** (with dates)**:**

**History of illness** (including tests and investigations)**:**

**Treatment(s)** (with dates)**:**

**Medical History:**

**Current physical status AKPS:** Please circle

- Normal; no complaints; no evidence of disease **100**
- Able to carry on normal activity; minor sign of symptoms of disease **90**
- Normal activity with effort; some signs or symptoms of disease **80**
- Cares for self; unable to carry on normal activity or to do active work **70**
- Able to care for most needs; but requires occasional assistance **60**
- Considerable assistance and frequent medical care required **50**
- In bed more than 50% of the time **40**

**Psychological status** (with details of relevant medication):

**Referral request to Blythe House Services**
(tick as appropriate)

**Living Well Service (Tues/Weds)** ☐
**Living Well Higher Dependency Day (Thurs)** ☐
**Living Well service for Carers** ☐

## Blythe House Audit

**Referral received by:** **Date:** **Referral Book No:**

**Date of Triage:** **Referral priority: High / Medium**

**Date Assessment offered:** **Date of Assessment:**

**Standard Achieved: Yes / No** **If No give reason:**

**Key Worker:** **iCare code:**