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.

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**

Date diagnosed:

Diagnosis:

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

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

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

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:**