Essex County Council NHS Essex Partnership University NHS Foundation Trust

Referral to Health and Social care for Adult Community Services West Essex

Single Point of Access

Date & time referral made:	**Date & time referral received:**
ADULT / PATIENT DETAILS: Name: Address: Post Code: Telephone number: Date of Birth: Ethnicity: NHS Number: Mosaic Number: Date of discharge (hospital only):	**REFERRER'S DETAILS**: Name (Inc. Ward Name): Contact Address: Contact Telephone Number: Relationship to patient: GP SURGERY DETAILS:
NEXT OF KIN CONTACT DETAILS:	**CARERS CONTACT DETAILS** (IF APPLICABLE):
HEALTH SERVICE REQUIRED: Please specify **SOCIAL CARE REQUIRED: Please specify**	**LEVEL OF URGENCY REQUESTED** ☐ 2 HOURS ☐ 24 HOURS ☐ 4 HOURS ☐ROUTINE ☐ OTHER – SPECIFY DATE If the request is within 4 hours it must be followed up with a phone call to SPoA number below. **ACCESS TO PROPERTY**: Key safe number: Any known environmental risks (EXPLANATION):
REASON FOR REFERRAL: **IS THIS ADULT / PATIENT HOUSEBOUND?** ☐**YES** ☐**NO** ☐Can patient be contacted directly ***PLEASE NOTE THAT ANY REQUEST FOR MEDICINE ADMINISTRATION MUST HAVE A SIGNED MEDICAL AUTHORISATION PROVIDED***	
RELEVANT PAST MEDICAL HISTORY AND CURRENT CONDITIONS (**MUST ATTACH SUMMARY OR RELEVANT DISCHARGE SUMMARY IF APPROPRIATE/APPLICABLE**):	

Please return form and supporting documents to:

For any queries/enquiries, please contact Single Point of Access on T: 01279 827524, F 01279 827827 (V12)

SAMPLE - DO NOT USE