**Referral Form To Single Point Of Access For Adult Community Services**

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| **Date & time referral made:** | **Date & time referral received:** | | |
| **PATIENT DETAILS**:  Name:  Address:  Post Code:  Telephone number:  Date of Birth:  Ethnicity:  NHS 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 TICK):  ☐ Community Nursing  ☐ Community Matron  ☐ Community Physiotherapy  ☐ Community Occupational Therapy  ☐ Community Phlebotomy  ☐ Community Dietician  ☐ Specialist Nursing ……………………………………………..  ☐ Rapid Assessment Clinic  ☐ Step Up Crisis Care Community Bed  ☐ Step Down Rehab Community Bed **(Hospital Referral only)**  ☐ Other …………………………………………………………………… | **SOCIAL CARE SERVICE REQUIRED** (PLEASE TICK):  ☐ Integrated Reablement | | |
| **LEVEL OF URGENCY REQUESTED** (PLEASE TICK): | | |
| ☐ 2 HOURS  ☐ 4 HOURS | ☐ SAME DAY☐ NEXT DAY | ☐ ROUTINE  ☐ OTHER – SPECIFY DATE |
| **ACCESS TO PROPERTY**:  Location of patient (room):  Key safe number:  Any known environmental risks (EXPLANATION): | | |
| **REASON FOR REFERRAL**:  **IS THIS PATIENT HOUSEBOUND?** ☐**YES** ☐**NO** ☐Can patient be contacted directly | | | |
| **RELEVANT PAST MEDICAL HISTORY AND CURRENT CONDITIONS** (**MUST ATTACH SUMMARY OR RELEVANT DISCHARGE SUMMARY IF APPROPRIATE/APPLICABLE**): | | | |
| **CURRENT MEDICATION** (DRUGS LIST AND KNOWN ALLERGIES): | | | |
| **SOCIAL CARE ARRANGEMENTS IN PLACE** (IF KNOWN):  ☐ Lives alone in own home with no care  ☐ Lives with family/spouse with no formal care  ☐ Lives in own home with care package in place  ☐ Long term residential care  ☐ Long term nursing care  ☐ Warden controlled accommodation  ☐ Currently inpatient in acute/community bed | **MENTAL HEALTH STATUS** (IF RELEVANT):  Any current cognitive problems:  Formal diagnosis of dementia:  Other mental health diagnoses:  If yes, please specify:  Already known to specialist mental health teams: Yes/No | | |

Please return form and supporting documents to: [epunft.SinglePointOfAccess@nhs.net](mailto:epunft.SinglePointOfAccess@nhs.net)

For any queries/enquiries, please contact Single Point of Access on 01279 827524 (t), 01279 827827 (f) V4