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| **REFERRAL FORM** **FROM HEALTH PROFESSIONALS** **TO WEST BERKSHIRE ADULT SOCIAL CARE**  |  **west berkshire council logo** |

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| NHS Number | LA Number |
| **Referrer name**, position and telephone: | **Reason for referral:**  |
| **Date and Time of Referral:**  |  | **GP** Name, address, telephone ,fax: |
| **PATIENT’S NAME:** D.O.B:Has Patient Consented to Referral: YES/NODoes the Patient Live Alone: YES/NO/NK | **Patient’s Address:**Postcode: Telephone Number:  |
| How can Access be gained?Who is key holder?Keysafe number?NOK details:  | Is the patient Cognitively impaired? YES/NO/NKHistory of Mental Health? YES/NO/NKDetails:Family or other advocate, name and contact details: |
| Patient’s Ethnicity: Patient’s Main Language: Interpreter Needed? YES/NO/NK | Is the patient a major care giver for someone? YES/NO/NKOr relies on someone who cares for them? YES/NO/NKWho? – name and phone no:Care Agency:  |
| Is the patient recently bereaved? YES/NO/NK (in the last 6 months)  |
| **Medical conditions/history:**  |
| **Functional Abilities:**Transfers –Mobility –  | Washing and Dressing –Toileting – Meal preparation - |
| **Any Known Risks to visitors/professionals:** |
| **Present Concerns:** |
| **Social History:** |