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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/NO  Does 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/NK  History of Mental Health? YES/NO/NK  Details:  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/NK  Or relies on someone who cares for them? YES/NO/NK  Who? – 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:** | | | | |