|  |  |  |
| --- | --- | --- |
| **Patient details:** | | |
| Surname: First Names: | Preferred Name: | Marital Status: |
| DOB: | Age: | Occupation: |
| Address: | | Ethnic origin: |
| Belief/Culture: |
| NHS number: |
| Postcode: | | Any additional needs required/identified: |
| Home Tel: | |
| Mobile Tel: | |
| Email Address: | |

Logo, company name

Description automatically generated

Day Service Referral

|  |  |
| --- | --- |
| **Emergency Contact Details:** | |
| Name: | Relationship: |
| Address: | |
| Postcode: | |
| Home Tel: | |
| Mobile Tel: | |

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| --- | --- | --- | --- |
| **Referrer Details:** | | | |
| Name: | | Job Title: | |
| Date: | | Contact No: | |
| **Reason for referral:** | | | |
| Wellbeing Sessions | Community Support | | Carer Advice Service |
| Complementary Therapy 1:1 Session | Befriending Service | | Complementary Therapy Group |
| Emotional Support | Bereavement Counselling | | Social Worker |
| Counselling for people with a life limiting illness | Cancer Support Group | | Craft Group |

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| --- | --- |
| Logo, company name  Description automatically generated**Medical Information:** | |
| Primary Diagnosis: | |
| Post/Current Treatment: | |
| Are there any Infection Control issues identified? **Yes**  **No**  **If yes please specify:** | |
| Is patient aware of diagnosis/prognosis? | **Yes**  **No** |
| Is Next of Kin/Main Carer aware of diagnosis/prognosis? | **Yes**  **No** |
| DNAR Decision/Respect Document: | **Yes**  **No** |
| Allergies, Drug/Food related. Allergens/Sensitivities: | |
| Patient aware of referral: | **Yes**  **No** |
| Consent to Share Medical Information: | **In**  **Out** |

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| **Current problems & specific aims of referral:** |
| 1. **What has prompted you to refer today? What do you/the person being referred want to get out of being referred to Great Oaks?** |
| 1. **Are there any physical symptoms?** |
| 1. **Functional – mobility, activities of daily living – Does the person being referred need support with their functional ability?** |
| 1. **Social – are there any other professionals involved? Who is their family/social network? Are here any other adults needing support? Are there any financial or housing concerns?** |
| 1. **Psychological – how is the person feeling? Are there concerns over their mental health/well-being? Does the person being referred have capacity? Are there any suicidal thoughts being expressed?** |
| 1. **Spiritual – Are they religious or part of a spiritual community? What sustains them at difficult times? Are you aware of any spiritual fears or anxieties?** |
| **Any other Support Services involved in care? (Name and contact details please)** |