**Referral Form To Single Point Of Access**

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| **Date & time referral made:** | **Date & time referral received:** |
| **PATIENT DETAILS**:  Name:  Address:  Post Code:  Telephone number:  Date of Birth:  CHI Number:  Date of discharge (hospital only): | **REFERRER’S DETAILS**:  Name (inc. Ward Name):  Role:  Contact Telephone Number: |
| GP SURGERY DETAILS: |
| **NEXT OF KIN CONTACT DETAILS** | **CARERS CONTACT DETAILS** (IF APPLICABLE): |
| **SERVICE REQUIRED** (PLEASE TICK) (if known):  ☐ Occupational Therapy Assessment  ☐ Physiotherapy Assessment  ☐ Long Term Care Assessment  ☐ Social Work Assessment  ☐ Equipment Assessment  ☐ Inpatient Request  ☐ Package of Care Request  ☐ Other | Can the patient be contacted directly? ☐**YES** ☐**NO**  Does the patient have capacity to consent to referral?  ☐**YES** ☐**NO** |
| **LEVEL OF URGENCY REQUESTED** (PLEASE TICK):  ☐ URGENT / SAME DAY  ☐ WITHIN 72 HOURS  ☐ ROUTINE  ☐ OTHER – SPECIFY DATE |
| **ACCESS TO PROPERTY**:  Location of patient (room):  Key safe number: Any known environmental risks (EXPLANATION): |
| **REASON FOR REFERRAL**:  Is there a change in baseline functioning? ☐ **YES** ☐**NO**  If yes, please state change:  **IS THIS PATIENT HOUSEBOUND?** ☐**YES** ☐**NO** | |
| **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 at home with care package  ☐ 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  If so, principle contact: |

Please return form and supporting documents to: [MidlothianFlowHub@nhslothian.scot.nhs.uk](mailto:MidlothianFlowHub@nhslothian.scot.nhs.uk) Phone 07827 880014