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| Edinburgh IMPACT referral form | | | | | | | | |
| Patient name:  Address:  Tel Number:  CHI: | | | | Referrer name:  Designation:  Base:  Tel Number: | | | | |
| Date of referral: | | | | Is patient aware of referral?  (please circle) Y N | | | | |
| (If not referrer)  GP name:  Address:  Tel number: | | | | | | | | |
| Main diagnoses (please list): | | | | | | | | |
| Reason for IMPACT referral: | | | | | | | | |
|  | | | | | | | | |
| Priority of visit and reason | | Other services involved  Name  Number | | | | | Environmental Risks? | |
| Medication | | | | | | | | |
| Number of unplanned hospital admissions  in previous 12 months:  Reason for admission:  Number of contacts with Out of Hours  services in previous 12 months: | | | | | If in hospital:  Planned date of discharge:  Actual date of discharge: | | | |
| MUST  SCORE | DEPRESSION  SCORE | | MMSC | | | WEIGHT | | HEIGHT |

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| **To refer please send completed form to**  [**impact.clinical@nhslothian.scot.nhs.uk**](mailto:impact.clinical@nhslothian.scot.nhs.uk)  **GP can refer via SCI gateway**  **IMPACT Single Point Of Contact Telephone Number - 07917 215 009**  **NB: The above number is for Professional use only**  **If possible please attach a patient summary sheet** | **NHS_Lothian_faxlogo** |