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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 involvedNameNumber | Environmental Risks? |
| Medication |
| Number of unplanned hospital admissionsin 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:  |
| MUSTSCORE | DEPRESSION SCORE | MMSC | WEIGHT | HEIGHT |

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| **To refer please send completed form to****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** |