**Referral Form to Single Point of Access**

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| **PATIENT DETAILS**:Name: Address:Post Code: Telephone number:CHI/ DOB: Date of discharge (hospital only): | **REFERRER’S DETAILS**:Name: Role/ Place of work: 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[ ]  Falls 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 consent to referral?[ ] **YES** [ ] **NO** |
| **LEVEL OF URGENCY REQUESTED** (PLEASE TICK):[ ]  URGENT / SAME DAY[ ]  WITHIN 72 HOURS[ ]  ROUTINE[ ]  OTHER – SPECIFY DATE*Please note – community teams will triage referral based on information given. Requested urgency level may not be appropriate/ achievable.* |
| **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:** |
| **MANDATORY INFORMATION****Is this patient housebound?** [ ] **YES** [ ] **NO** ***FRAILTY SCORE IF KNOWN* (1 – 9):** **DNACPR IN PLACE?** [ ] **YES** [ ] **NO** [ ] **NOT KNOWN****Do you believe the patient has the capacity to consent to referral?** [ ] **YES** [ ] **NO****Has a formal capacity assessment been done?** [ ] **YES** [ ] **NO** [ ] **NOT KNOWN (please provide details if known)** |
| **RELEVANT PAST MEDICAL HISTORY AND CURRENT CONDITIONS**:  |
| **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/NoIf so, principal contact: |

Please return form and supporting documents to: MidlothianFlowHub@nhslothian.scot.nhs.uk Phone enquiries: **07827 880014**