**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/No  If so, principal contact: |

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