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**Broad Lane, Rochdale, OL16 4PZ**

**Tel. 01706 649920. Fax. 01706 644943**

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**REFERRAL FORM**

**DAY THERAPIES**

**Peer Support Group for Families and Carers**

|  |
| --- |
| **Is the client aware that this referral has been made? Yes □ No □****Is the client’s GP aware that this referral has been made? Yes □ No □****\*\*Please note this referral will only be processed if the client is aware and has given consent\*\*** |

**Client/Carer details:**

|  |  |
| --- | --- |
| Surname:  | Date of Birth:  |
| First name:  | Gender: |
| Address:  | Ethnicity: |
| Language: |
| Postcode:  | Title: |
| Tel. No. | Marital status: |
| Mobile. No. |  |

**Patient information:**

|  |  |
| --- | --- |
| Name: | Relationship to patient: |
| Diagnosis: |  |
| Must be a palliative life limiting condition |  |

**Emergency contact details:**

|  |  |
| --- | --- |
| Surname | Address:  |
| First name: |
| Relationship to patient | Postcode: |
| Tel. Number: |

**Referrer details:**

|  |  |  |
| --- | --- | --- |
| Name: | Address: | Tel. Number: |
| GP □ | Consultant □ | Specialist Nurse □ | District Nurse □ | Other □ (specify) |

**GP/Other services involved:**

|  |  |
| --- | --- |
| GP name:Address:Tel. Number: | Other (please specify) |
| Other (please specify) |

**Person completing referral:**

|  |  |
| --- | --- |
| Print Name:Signature: | Designation:Tel No:Date: |