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

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

**Email.** nehgm.liaison@nhs.net

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**REFERRAL FORM**

**DAY THERAPIES**

**\*\*Please attach any relevant clinical information/letters/contact assessments\*\***

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

**Patient details:**

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

**Patient information:**

|  |  |
| --- | --- |
| Diagnosis: | Location of patient: |
| Date of Diagnosis | Home □  |
| Hospital Number: | Hospital □ (please specify Hospital & ward) |
| NHS Number: | Does the patient live alone? Yes □ No □ |

**Next of Kin/Carer 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:Fax: | Specialist Nurse name:Tel. Number: |
| District Nurse Name:Tel Number |
| Other (please specify) |

|  |
| --- |
| **Reason for referral:** *(Please indicate current problems and specific aims of referral)* |

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| --- |
| **Other relevant medical history:** *(Past medical history, other current illnesses, treatments, outcomes, prognosis)* |

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| --- |
| **Nursing/Physical:** *(Activities of Daily Living, bowels, appetite, mobility, dressings, wounds, IV therapies, day-to-day nursing needs of patient)* |

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| **Social situation:** *(Housing, family, financial, community support, access to property, are there any foreseeable risks?)* |

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| --- |
| **Emotional/psychological/spiritual/insight:** *(Knowledge of illness, prognosis, feelings and fears, importance of religion, communication barriers for both patient & carer, ability to make decisions)* |

|  |
| --- |
| **Present medication:** *(Please list medication, dose and frequency here OR send current drug list)* |

|  |  |
| --- | --- |
| **Self-Management Supportive Group Programme** □**Wellbeing Group Programme** □ | **If patient is online:** **Virtual Wellbeing Group Programme □** |

|  |  |
| --- | --- |
| **Further information:**North West Model for Life Limiting Conditions Advance Care Plan Yes □ No □uDNACPR form? Yes □ No □ | Key-safe in place Yes □ No □Preferred place of care Yes □ No □(if yes, please state where …………………………. ) |

|  |  |
| --- | --- |
| **Person completing referral:**Print Name:Signature: | Designation:Tel No:Date: |