****

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

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

**Email.** [nehgm.liaison@nhs.net](mailto:nehgm.liaison@nhs.net)

**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: |