|  |  |
| --- | --- |
| Date of Referral:  Time of Referral: | |
| Client’s consent to contact AUKL given Yes No  *This service is available to anyone over 18* | |
| Referrer’s details | |
| Referred by (Name and Role) |  |
| Referrers Location (Hospital/Ward/Dept/Community) |  |
| Referrers Contact No. |  |
| Would you like AUKL to transport the patient home? | |
| Yes No | Expected date and time \_\_\_\_\_\_\_\_\_\_\_\_  ***If today****, please call the office ASAP, see footer.* |
| Client’s details | |
| NHS/LAS Number |  |
| Mr  Mrs  Miss  Ms |  |
| First Name |  |
| Last Name |  |
| Date of Birth |  |
| Gender |  |
| Ethnicity |  |
| Address |  |
| Telephone number/s |  |
| Client lives | Alone  With partner  With Family |
| Emergency contact | |
| Name |  |
| Telephone number |  |
| Relationship |  |
| GP Surgery |  |
| Telephone number |  |
| Client’s Health and Social Care | |
| Are there any current infections or Infection Prevention Control measures in place for the client?  *If yes, please give details:*  Yes  No | |
| Was this client admitted to hospital? Yes No | |
| What was the reason for admittance? | |
| What ward is the client on or being discharged from? | |
| Date of discharge: | |
| Is this a community referral to prevent a hospital admission? Yes No | |
| Does client have symptoms or issues linked to NHS Core20Plus5 conditions below? | |
| Tick all that apply | Hypertension |
| Chronic Respiratory Conditions | Cancer |
| Maternity Care | Severe Mental Illness |
| What is the client’s current illness if a community referral? | |
| Any other health concerns we should be aware of?  Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No | |
| Care Arrangements | |
| Crisis Care in place? | Yes No |
| Reablement in place? | Yes No |
| Long term care package in place? | Yes No |
| Reason for referral to AUKL Living Well Support Service | |
| Help with shopping | |
| Help with cleaning | |
| Support to become more independent (*Please give details)* | |
| Referring and signposting to other services | |
| Reduce social isolation | |
| Enable benefit checks | |
| Provide moral support | |
| Advice and support to obtain equipment and alarms | |
| Any other goal/need *(Please give details)* | |
| Risk Assessment | |
| Please list any potential risks that may affect our ability to provide support  *This could include environment/dementia/unpredictable behaviour/mobility/other individuals living in the premises* | |
| Smokers in the property? (Including E Cigs) Yes No  *Ask to refrain from smoking before and during visit* | |
| Pets or animals in the property? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No  *Ask for any pets to be kept in another room if noisy, aggressive, allergies present etc* | |
| Access to (and location of) the property – e.g. parking provision, steps, uneven ground, key safe, visibility? | |
| Any other people likely to be in the property? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No | |
| Any other potential risks or hazards our staff need to know about? | |

***Thank you for your referral***