|  |
| --- |
| 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? [x] 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***