Support and Independence Team

Referral

Please complete the white boxes below and email to: gatewaytocare@calderdale.gov.uk

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| **Service User** | | | | |
| Name |  | | | |
| Address |  | | | |
| Post Code |  | Date of birth |  |
| Telephone number |  | | NHS number |  |
| GP |  | | CIS number |  |

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| --- | --- |
| Location of Service User now |  |

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| --- | --- |
| **Important**: please indicate the service required |  |

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| --- | --- |
| **Referrer** | |
| Your name |  |
| Telephone number |  |
| Email address |  |

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| **Referrals for Reablement ONLY** | | | |
| Does the person have the mental capacity to consent to this referral? | No | Yes |  |
| If “No”, has a best interest decision been completed? | No | Yes |  |
| If “No” **to both questions, *you cannot proceed to reablement.*** | | | |

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| **Referrals for Falls Prevention ONLY** | | | | |
| Is there a history of falls in the previous year? | No | Yes | How many? |  |
| Is the person on 4 or more medications per day? | No | Yes |  |  |
| Does the person have a history of stroke or Parkinson’s disease? | No | Yes |  |  |
| Does the person have problems with their balance? | No | Yes |  |  |
| Is the person **unable** to rise from a chair of knee height without using arms? | No | Yes |  |  |
| Are the falls indoors or outdoors? | Indoors | | Outdoors | |

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| **Situation: what is happening at the present time? What is the cause?** |
| *Please include the following details*  *Referred by and what their designation is / Consultant if known / Clarify if consent for referral obtained and consent for sharing information* |

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| **Background: what are the circumstances leading up to this situation?** |
| *Please include the following details*  *Location of the individual and if in hospital / community bed how long have they been there for /*  *Expected date of discharge / Are they appropriate for a lone worker to visit, if not please state risks* |

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| **Assessment: what do you think is the problem?** |
| *Please include the following details*  *Reason for referral / Previous level of function / Level of support already in place e.g. POC, family support etc /*  *Relevant medical history if known*  Communication -  Cognition/capacity -  Washing and dressing -  Toileting/ Continence/ skin integrity-  Fluid and diet intake/ dietary requirements-  Mobility -  Medication -  Shopping/ household tasks/finance-  Equipment -  Psychological/ emtoional issues -  Past medical history -  Property and access -  Additional information - |

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| **Recommendation: what should we do to correct the problem? What should be the action plan?** |
| *Please include the following details*  *Recommendation for further action / Referred onto e.g. urgent staff member deployed, locality team, specialist team* |