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*     |