**LATER LIFE PLANNING**

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Description automatically generatedINFORMATION AND ADVICE SERVICE**

**PROFESSIONALS REFERRAL FORM**

**Client’s Details (All fields must be completed)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client’s consent for this referral** | | Click to select | |
| Title | Click to select | Mental Capacity ? | Click to select |
| First Name | Click to enter text | Date of Birth | Click to enter date |
| Family Name | Click to enter text | Gender | Click to select |
| Address | Click to enter text | Landline no. | Click to enter text |
|  |  | Mobile no. | Click to enter text |
| Postcode | Click to enter text | Email address | Click to enter text |
| Ethnicity | Click to select | Marital Status | Click to select |
| Main Language | Click to enter text | Interpreter needed? | Click to select |
| Living Arrangement | Click to select | Preferred contact method | Click to select |
| Accommodation Type | Click to select | Have a carer? | Click to select |

|  |
| --- |
| **Communication Needs** Please provide more information if the client has communication problems related to sensory impairments (including speech, hearing and visual impairments etc) and cognitive impairments (including memory problems, mental health problems and learning difficulties and disabilities etc).  Click to enter text |

**Client’s Next of Kin**

|  |  |  |  |
| --- | --- | --- | --- |
| Title | Click to select | Power of Attorney | Click to select |
| First Name | Click to enter text | Age | Click to enter text |
| Family Name | Click to enter text | Gender | Click to select |
| Address | Click to enter text | Landline no. | Click to enter text |
|  |  | Mobile no. | Click to enter text |
| Postcode | Click to enter text | Email | Click to enter text |
| Relationship | Click to enter text | Primary carer ? | Click to select |

**Reason for referral**

|  |
| --- |
| Please provide a brief account of client’s circumstances and the reason/s for referral.  Click to enter text |

**Risk Assessment (All fields must be completed if home visits are required)**

|  |  |  |
| --- | --- | --- |
| 1) Have you met the client?  Yes  No  2) From you understanding, is there any reasons the client should not be visited alone?  Yes  No  3) If your answer for question 2 is yes, please select relevant boxes below and provide more information. | | |
| Verbally abusive/intimidating or threatening behaviours |  | Please provide information relevant to the selected conditions.  Click to enter text |
| History of Violence/aggression |  |  |
| Self-neglect/Self-harm/Suicidal |  |  |
| Substance misuse |  |  |
| Racial / Gender issues |  |  |
| At risk from others |  |  |
| Other risks to others |  |  |
| Any other safe-guarding concerns |  |  |

**Existing Care and Support (check all that apply)**

|  |  |  |
| --- | --- | --- |
| Has the client been assessed by Social Services? |  | Please provide more information about client’s existing care/support.  Click to enter text |
| If so, are they receiving a care package? |  |
| Has an OT assessment been done? |  |
| Is the client supported by other agencies/voluntary organisations? |  |

**GP Details and Medical Conditions**

|  |  |  |
| --- | --- | --- |
| GP’s name | Click to enter text | Please provide more information for known medical and mental health conditions.  Click to enter text |
| Practice | Click to enter text |
| Address | Click to enter text |
| Contact no. | Click to enter text |
| Email address | Click to enter text |

**Professional Referrer’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Click to enter text | Role/Job title | Click to enter text |
| Organisation | Click to enter text | Referring date | Click for calendar |
| Tel / Mobile | Click to enter text | Email | Click to enter text |

**Please return this form by email or by post to:**

Email address [LaterLifePlanners@ageukbarnet.org.uk](mailto:LaterLifePlanners@ageukbarnet.org.uk)

Postal address Later Life Planning Advice Team, Age UK Barnet, Ann Owens Centre, Oak Lane

London N2 8LT

Helpline 020 8432 1417 (open Monday to Thursday from 10:00 – 13:00)

**THIS SECTION IS FOR INTERNAL USE ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| Acknowledged Referral | Yes  No | Accepted Referral | Yes  No |
| Assigned to | Click to enter text | Assigned on | Click for calendar |