**REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | Tel Number of Client |  |
| Title |  | Surname |  |
| First name |  | Age/DOB |  |
| Gender | Male / Female / Undefined | Ethnicity |  |
| Address |  |
| Postcode |  | Is the client disabled | Yes / No |
| If yes, what is the nature of the disability? |  |
| Dalhousie frailty score? *Please circle appropriate* | Severe / Moderate / Mild / Not Applicable |
| NHS number |  |
| Tenure:*(please circle)* | Private homeowner / Private Tenant / Council Tenant /Housing Association / Homeless / Other (please define) |
| Referrer/Organisation |  |
| Organisation/ contact number  |  |
| Reason for Referral |
|  |
| Please list any known current benefits the client is in receipt of |
|  |
| **Risk Assessment:** Are there any known risks that we should be aware of prior to a visit by a Care Navigator?  |
|  |
| KCC Caseworker |  | GPSurgery |  |
| Any other Relevant professional involved |  |
| Has this client been known to our service before |  Yes / No |
| Alternative Contact Details:Name:Tel number:Address:Relation to client |
| Office use Only: |
| Date Referral received |  |
| Date passed to Care Navigator |  |
| Care Navigator |  |

Please send this form to: skc.carenav@nhs.net

Enquiries Tel: 0800 028 3172 (Option 2)