**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 |  | | | GP  Surgery |  |
| 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](mailto:skc.carenav@nhs.net)

Enquiries Tel: 0800 028 3172 (Option 2)