

**LIVING WELL SERVICE - REFERRAL FORM**

**Date:**

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| **SERVICE USER DETAILS** | | |
| **Title:** | **First Name:** | **Surname:** |
| **Gender:** | **DOB:** | **Telephone no.:**  **Mobile no.:** |
| **Address:**  **Postcode:** | |

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| **REASON FOR REFERRAL (Please complete each reason applicable)** |
| **At risk of unplanned hospital admission (please explain):**  **Recent change in circumstances eg health diagnosis, bereavement, reduced social contact (please explain):**  **Other (please specify):** |

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| **RISKS** |  |
| **Are you aware of any risks to anyone visiting the service user’s home?** | **Yes / No (If yes, please provide details)** |
| **Are you aware of any cognitive impairment?** | **Yes / No (If yes, please provide details)** |

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| **EMERGENCY CONTACT DETAILS** | **Contact 1** | **Contact 2** |
| **Name** |  |  |
| **Contact no.** |  |  |
| **Mobile no.** |  |  |
| **Relationship** |  |  |

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| **GP DETAILS** |
| **Surgery Name:** |
| **Name of Doctor:** |
| **Address:** |
| **Contact no.:** |

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| --- | --- |
| **REFERRED BY** | |
| **Name of Referrer:** | |
| **Designation:** | |
| **Contact details:** | |
| **Has the service user consented to the referral?** | **Yes / No (Please note we are unable to accept a referral without consent)** |

**Please email this form to** [**livingwell@ageuknotts.org.uk**](mailto:healthandwellbeing@ageuknotts.org.uk) **or** **telephone 0115 8599206**