

**LIVING WELL SERVICE - REFERRAL FORM**

**Date:**

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

|  |
| --- |
| **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):** |

|  |  |
| --- | --- |
| **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)** |

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

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

|  |
| --- |
| **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** **or** **telephone 0115 8599206**