 **Form for Referral to the Nightingale Service**

**Person must be a RESIDENT of London Borough of Richmond upon Thames**.

**Age 65+**

**Living alone or with another vulnerable person**

**\*COVID 19 \*  PLEASE SEE ADDITIONAL INFORMATION REQUIRED**

|  |  |
| --- | --- |
| **Name of Person**  |   |
| **Address**     |   |
| **Phone number**  |   |
| **Date of Birth**  |   |
| **Gender**  | **M/ F/ Non-Binary/ Transgender/ Other/ Prefer not to say** |
| **Religious Group**  |   |
| **Ethnicity**  |   |
| **Marital Status** |  |
| **Sexual Orientation**  |   |
| **Other people in household**  | **Anyone self-isolating/ experiencing symptoms**  |
| **Is this person a carer?**  |   |
| **Next of Kin details** **Name** **Address** **Telephone** **Email**  |   |
| **Referrer’s details** **Name:** **Hospital/ ward:** **Contact number / bleep:** **Email address:**  |   |
| **Reason for admission/ date**  |   |
| **Reason for referral** **EDD/ urgency**   | \***Please note new info on shopping services in box below:**   |
| **GP Practice**     |   |
| **Their NHS number**  |   |
| **Health conditions** **Including:** **Cognition** **Mobility** **Sensory impairments** **MRSA +** **Any relevant risk factors \***  | **\*Covid 19 – please complete the relevant information:** **Diagnosis date.** **End of isolation period.****1st vaccination. Y/N/ unknown****2nd vaccination. Y/N/ unknown** **Please give dates if known**  |
| **Shopping services:** **Please ensure the client has funds to pay by cash or card.**   |   |
| **Package of care details** **Provider:** **Contact details:**  |   |
| **Any other important contacts** **Warden** **Key-holders** **Neighbours** **Any informal support?**  |    |
| **Date of consent / referral**  | **Consent:**   | **Referral:**  |

**If you are making a referral for a Keysafe (permission agreed) and you have the following property information, with details if known, it would be most helpful:**

|  |  |  |
| --- | --- | --- |
| **Owner occupied:**    | **Private landlord: (permission given)** **☐Yes** **☐No**  | **Housing association** **Name:** **Contact Numbers:** **(permission given)** **☐Yes** **☐No**  |
| **Parking:** **Off street:** **Resident parking:**  |
| **If client in hospital, who can give access:**    |
| **Location of Keysafe, e.g. by flat door within sheltered block**    |
| **Has client chosen a number?** *(5 digit number with no repetitions and no more than 2 consecutive numbers or 4 digit number with A or B at beginning or end)* **Yes****No** **Code:** **This section MUST be completed.****It is important that the keysafe code is stored on our secure database system. PLEASE NOTE there is a charge to fit a new keysafe if the original code is forgotten.****Please confirm consent for code to be stored.****Yes Yes No** |
|  |

**Main telephone contact**: 07873 888 544: **Office telephone:** 020 8876 2449

**Please send this completed form to**:

**By email**: nightingale@ageukrichmond.org.uk

**By Post**: Age UK Richmond upon Thames, Nightingale Service, The White House, 45 The Avenue, Hampton TW12 3RN