 **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](mailto:nightingale@ageukrichmond.org.uk)

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