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| **COMPASSIONATE NEIGHBOUR SERVICE**  **REFERRAL FORM** | | | | | | |
| **\*\*PLEASE NOTE\*\*** | **Does the client have a palliative diagnosis?**  Yes  No | | | |  | **If no, then we will not be able to accept the referral as it is outside our criteria** |
| **CLIENTS NAME:** |  | | | | **DOB:** |  |
| **Gender**  ***(Optional)*** |  |  | **Home Address** |  | | |
| **Phone – Home** |  | |
| **Phone – Mobile** |  | | **Client living**  **alone** | Yes  No | | |
| **GP Name & Surgery** |  | | **GP Phone** |  | | |
| **Main Carer (if applicable)** |  | | **Relationship** |  | | |
| **Address (if different to patient address)**  **Contact No:** |  | | | | | |

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| **Current location of client? Home**  **Care Home  Hospice**  **Sheltered accommodation**  **Other** | | | | | | |
| **Referred By:** | **District Nurse** | **CNS** | **Ward Nurse** | **GP** | **Doctor** | **Other / Role** |
| **Name:** |  | | **Organisation -**  **(Phone No):**  **(Bleep No):** |  | | |
| **Signature:** |  | | **Date:** |  | | |

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| **MEDICAL DETAILS** | **Is the client permanently confined to bed:**  Yes  No | | **Is the client known to the Hospice?**  Is so which service.  Inpatient Unit  OPD  Outreach Services  No | **Is there a care package in place.**  Yes – if so, what is the package:  No |
| **Has the client been diagnosed or waiting for a referral for Dementia/Alzheimer’s?**  Yes  No | | **Are there any Safeguarding issues:**  Yes – if so, what are they:  No | | |
| **Has the client been able to leave the home by themselves in the past 12 months?** | | Yes  No  If no, why not: | | |
| **Does the client or anyone else living in the house have any health issues (physical or mental:** | | Yes – if so, what are they:  No | | |

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| **Are there any communication issues** | Yes  No  If Yes what are they: |
| **To your knowledge is there any known substance abuse or alcohol use both historical and current either with the client or any person who lives in/visits the property?** | Yes  No  If yes, what are they: |
| **Is the client known to any other services?** | Yes  No  If yes, what are they: |
| **Are there any pets in the property?** | Yes  No  If yes, what are they: |
| **What does the client need from the service that we offer?** |  |

We are experiencing high levels of demand for this service.

Please be assured we haven’t forgotten about your referral and will be in touch with your referral very soon.