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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[ ]  NoIf 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[ ]  NoIf 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[ ]  NoIf yes, what are they: |
| **Is the client known to any other services?** | [ ]  Yes[ ]  NoIf yes, what are they: |
| **Are there any pets in the property?** | [ ]  Yes[ ]  NoIf 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.