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| --- | --- |
| **Criteria for referral:** | **Tick or quantify as appropriate:** |
| Adult **age 50 or over**, **and** |  |
| Resident of: Burnley, Pendle, Rossendale, Hyndburn, or Ribblesdale |  |
| **Mental Health diagnosis** | Yes | No – if no, not eligible for this service | **Please specify Diagnosis** |
| If Carer/family member-please specify |  |
|

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| **Number unplanned Hospital admissions:** |
| **Please confirm other key high -risk indicators and condition/support required.****Frailty Score (if known)** |

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| **Does the client consent to this referral?** **THIS INCLUDES ADDITION TO THE AGE UK SECURE DATABASE (CHARITY LOG)**  | YES/NO | **Date Referral Made:** |

|  |
| --- |
| **Client Details:** |
| Full Name: |  | DOB: |  |
| Full Address: |  | Key safe: | YES/NO Code: |
| Tel: |  | Gender: |  |
| **GP Name:** |  | Ethnicity: |  |
| **GP Practice:** |  | NHS No: |  |
| **Next of Kin or Emergency contact:** |
| Full Name: |  | DOB: |  |
| Full Address: |  | Key Holder: | YES/NO |
| Relationship: |  | Tel: |  |

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| **Reason For Referral: (i.e. presenting need, social inclusion, health issues, self-neglect etc)**  |
| **Please indicate-**

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| --- | --- |
| social  |  |
| connect to community |  |
| reduce loneliness. |  |
| emotional support |  |
| help to stay independent and manage condition. |  |
| self- neglect |  |
| other please specify: |  |

 |
| **Date of most recent hospital admission:****(If applicable)**  |  | **Approx discharge date:** |  |
| **Mandatory Box Please provide detail of any risk our practitioners may encounter: (This box must be completed or the referral will not be accepted)** |
| **Is it safe for a staff member to be alone with client? Yes / No** **If no, please state why..............................................................................................................................................****Client can participate in a group environment/activity? Yes/No****Is there a risk of infection? Yes / No** **If yes, please specify....................................................................................................................................................****Please include any additional information relevant to this referral EG: behavioural / mental health issues/medication details** |
| **Please indicate any other Agencies working with this client:** |

|  |
| --- |
| Your details as Referrer:- |
| Name: |  | Tel: |  |
| Email: |  | Team/Agency |  |

**PLEASE COMPLETE ALL SECTIONS OF THE FORM AND EMAIL TO** ageukintegrated.carereferrals@nhs.net

**Key Risk Indicators**

* Mental health diagnosis (please specify)
* Alcohol dependencies
* Hoarding
* Depression
* Isolated/lonely
* Anxiety
* Bereavement
	+ Extensive use of GP appointments/time
	+ Identified by a GP
	+ Identified through an INT
	+ Identified by Social Prescribers/Care Coordinators
	+ Rockwood Clinical Frailty Score of 4/5 or above
	+ On the caseload of Intensive Home Support Service
	+ Upon discharge (Integrated Discharge Service Or AUKL HAS
	+ Seen by Emergency Department front door team.
	+ Referral from Intermediate Care Allocation Team (ICAT)
	+ Identified by over 75’s nurses.
* Other CVFS Agencies identifying need.
* Self -Referral with consent to share info with health professionals

 Exclusions – who cannot be referred

Patients currently undergoing therapy elsewhere

Patients who are experiencing problems with substance/drug misuse and their needs could be met through specialist services.