|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  | |
| |  | | --- | | **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-**   |  |  | | --- | --- | | 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](mailto: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.