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| **Community Therapy Referral** | | |
| **Referral Date:** |  | * **Consent to referral** |
| * **Neighbourhood Team Therapy** – (No care needs or restarting existing package of care)   Send as below |  | * **Home First Therapy**  - (If referral to Adult Social care has been made also)   Send as below plus copy to Complex Discharge team (will replace therapy goal sheet) |
| **Email:** [**duty.therapy@nhs.net**](mailto:duty.therapy@nhs.net)  **Telephone: 01432 842244 Fax: 01432 347689**  **Post:**  **Referrals Hub, Vaughan Building, Wye Valley NHS Trust, Ruckhall Lane, Herefordshire HR2 9RP** | | |
| **Service Required:**   * **Physiotherapy** (Housebound Only) * **Occupational Therapy** * **Complex Moving & Handling** | | |
| **Patient Name & Address:**  **Date of Birth:**  **NHS No:**  **GP Surgery:**  **Telephone Number:**  **Next of Kin contact:** | **Alerts & Allergies:**  **Key safe / key safe number:**  **Can they be visited alone? Yes / No**  **Any pet to be aware of? Yes / No**  **Concerns with MCA Yes / No**  **Safeguarding in place Yes / No**  **DOLS in place Yes / No** | |
| **Recent admission details:**  **Admission date: EDD:** | **Current Location of Patient:** | |
| **Name & designation of referrer:** | **Referrer contact No:** | |

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| **Reason for referral:**  **Any other referrals made –** (e.g. Home First, Parkinson’s, neuro team, brain injury team, DN, Falls clinic)  **Known to social care:** yes / no **Existing care package details -** ASC**/**Private  **Does the patient pay council tax to Herefordshire?** Yes / No | |
| **Current and Relevant Past Medical History:**  **(To include current diagnosis, any surgery, precautions and contraindications):**  \*\*Medical summary attached – yes / no | **Current and previous functional levels**  **How does the patient walk? Do they use an aid?** |
| **How does the patient transfer on/off the bed/chair/toilet?** |
| **Any concerns with pressure areas:** |
| **Any problems or help needed with getting get washed and dressed:** |
| **Current medications list:** | **Any problems or help needed with preparing meals:** |
| **Any problems or help with taking their medication:** |
| **Any equipment already in situ (i.e. toilet seats, perching stools, commode, rails)** |
| **Accommodation details – (type / tenure)** |
| **What goals does the patient want to achieve?** | |

**Please ensure this form is completed in full.**