**REFERRAL FORM**

**Referrer**

|  |  |  |  |
| --- | --- | --- | --- |
| Referred by: |  | Date of referral: |  |
|  |  |  |  |
| Telephone: |  | Email: |  |
|  |  |  |  |
| Organisation & Address |  | Relationship: |  |
|  |  |  |  |

**Service User Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | D.O.B: |  |
|  |  |
| Address: |  |
|  |  |
| Postcode: |  |
|  |  |  |  |
| Tel Landline: |  | Tel Mobile: |  |

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| --- |
| **Current illness, difficulties and needs**  |
| Please provide as much information as possible. (Diagnosis, symptoms, medication, etc) Legal status if any. Brief Social History, support in place, ADL skills, and CPA Level)     |

**Physical Health Issues**

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| **SECTION 4 –RISK ASSESSMENT** |
| Risk to self:Risk to others (staff, neighbours, children, other tenants):Risk to property:Risk from others (Any Safeguarding issues)Risk of Arson: Has there ever been evidence of arson? If yes please provide details: |

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| --- |
| **Criminal Convictions** |
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| **Incidents in the last 6 months**  |
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**Additional Information (include here any drug or alcohol dependency or abuse)**

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**Client’s motivation and views on potential placement**

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| **Next of Kin:** Name: Relationship to Patient: Address:Telephone number:Email**GP Name:**Address:Telephone number:Email**Care Manager/Coordinator:**Address:Telephone number:Email**Social Worker:**Address:Telephone number:Email:  |

 **Significant others and Relevant Agencies involved in care:**

**Office use:**

|  |  |
| --- | --- |
|  |  |
| Date of assessment booked: |  |
|  |  |
| Notes: |  |
|  |  |

**Please return completed application form together with background information if available e.g. CPA Report, OT Report, etc.**

**Send completed form to:**

Email: referrals@kalincare.co.uk

**Enquiries:**

Phone:

Email: info@kalincare.co.uk