**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