**Referral form to Age UK Berkshire Services**

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| Service/ team/ Hospital Ward Name: |  |
| Name of Client’s GP:  Telephone Number: |  |
| Name of referrer:  Email address:  Telephone Number: |  |
| Referral Service Type Required: | |  |  | | --- | --- | | Home from Hospital | YES / NO | | Home Help Plus | YES / NO | | Handyperson | YES / NO | | Easyshop | YES / NO | | Information and Advice | YES / NO | | Befriending | YES / NO | | Welfare call/ Keeping in touch | YES/ NO | | Other services | YES / NO | | Carers Partnership | YES / NO | |
| Relevant information relating to this referral: |  |

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| Patient Details | |
| Clients Name & Address: |  |
| Date of birth: |  |
| E-mail address:  (if applicable) |  |
| Telephone Number  Carers/next of kin information if known or alternative contact: |  |
| Does the client have any Long Term Conditions: |  |
| Additional reason for referral (please tick box):   |  |  | | --- | --- | | Recently Bereaved |  | | Living Alone |  | | Reliance on avoidable GP contacts |  | | Socially isolated |  | | Having trouble managing medication(s) |  | | Not attending routine outpatient appointments |  | | Acting in a carer role but possibly struggling with the responsibility |  | | |
| Is there other relevant information that the staff visiting the client **at home** should be aware of: |  |
| How mobile is the client: |  |
| Relevant Social care package in place  Y/N/Unknown / Provider |  |

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| Date client consent obtained: | Date of referral: |