**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 |

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| Relevant information relating to this referral: |  |

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| Patient Details |
| Clients Name & Address: |  |
| Date of birth: |  |
| E-mail address:(if applicable) |  |
| Telephone NumberCarers/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 |  |

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| 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 placeY/N/Unknown / Provider |  |

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