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| **Name of Client Being Referred:** |

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| --- | --- |
| **Potential Client’s Address:-** | **Postcode:-** |
| **Potential Client’s Tel No/Mobile No:-** **Potential Client’s Email Address:** | **Potential Client’s DOB:-**  |
| **Name of Potential Client’s Next of Kin:-** | **Relationship to Potential Client:-** |
| **Next of Kin’s Address & Postcode:-****Next of Kin’s Email Address:** | **Next of Kin’s Tel No:-****Mobile Number:** |
| **Referrer’s Name/Organisation:-** | **Referrer’s Tel No:-** |
| **GENERAL INFORMATION ABOUT THE POTENTIAL CLIENT-** |

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| **Are they able to go to the toilet unaided? (If no, please do not proceed any further with the referral, as LLCG are unable to provide personal care)** | Yes | No |
|  |  |
| **Do they have a diagnosis of Dementia or any other cognitive impairment? (*Please give details)*** | Yes | No |
|  |  |
| **Are they, or anyone else in the household a smoker?**  | Yes | No |
|  |  |
| **Are there any pets in the household?** | Yes | No |
|  |  |
| **Any mobility support needs and/or use any walking aids? *(Please give details)***  | Yes | No |
|  |  |
| **Do they have any known allergies or intolerances to anything? Any dietary/choking support needs*? (Please give details)*** | Yes | No |
|  |  |
| ***Cont. overleaf –*** |
| **Any have any visual support needs? *(Please give details)***  | Yes | No |
|  |  |
| **Any hearing support needs? *(Please give details)***  | Yes | No |
|  |  |
| **Any speech support needs? *(Please give details)***  | Yes | No |
|  |  |
| **Does the potential client live alone?** | Yes | No |
|  |  |
| **Do they currently receive support from other organisations? *(Please give details)*** | Yes | No |
|  |  |
| **Are there any risk concerns (e.g. alcohol, mental health, living in a challenging environment)? If yes, please give details.**  | Yes | No |
|  |  |

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| **Which service is the potential client being referred for *(Please tick one option only):***Help to Stay at Home Service – 1 hour house visitHelp to Stay at Home Service – 2 hour community visitDay Care Session**Reason(s) for referral:****Any other relevant information**: |