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| **Ivybridge/Yealm Intermediate Care and Community Therapy Team**  **Referral form - To be completed by referrer** | | | | | | | | |
| **Patient Details** | | NHS Number: | | | Hospital Number: | | | |
| Name | |  | | | Referral Date: | Date Received by Team: | | |
| Title: | | Date of Birth: | Gender: | | Marital Status: | Occupation | | |
| Address | | Postcode:  Tel no.:  E-mail address: | | | Next of Kin  Ethnicity: | Next of kin contact no.  Religious and spiritual beliefs: | | |
| **GP** | | GP name and Practice: | | | | | | |
|  | | Date of GP visit: If spot purchase Medical responsibility by : | | | | | | |
| **Referred by:**  Designation: | | | | Referrers contact no. and address: | | | | |
| Consent to share information gained - Yes/No Is patient aware of referral - Yes/No | | | | | | | | |
| **Checklist for prioritising urgency (please delete as appropriate)** | | | | | | | | |
|  | Would Therapy intervention help prevent deterioration or a hospital/care home admission | | | | | | Yes | No |
|  | Is the patient medically able to participate in a rehab programme? | | | | | | Yes | No |
|  | Is the patient’s safety being compromised? | | | | | | Yes | No |
|  | Does the patient live alone? | | | | | | Yes | No |
|  | Does the patient have a clinical need to be seen at home? | | | | | | Yes | No |
|  | Has the patient recently been discharged from hospital? | | | | | | Yes | No |
|  | **Date of hospital discharge** | | | | | |  | |
| Diagnosis: | | | | | | | | |
| Reason for Referral: *(including any risk factors)*  Allergies: | | | | | | | | |
| Any other relevant information: *(including past medical history) COPY OF LETTER TO PATIENT: Y / N* | | | | | | | | |
| Medication: known allergies: *(Please attach a patient profile)*:  Allergies: | | | | | | | | |
| **To make a referral please e-mail to:**  **Ivybridge/Yealm Community Therapy Team, The Hayloft, St. Olaf’s Chapel, Puslinch, Yealmpton, PL8 2NN**  **Telephone: 01752 434906 E-mail:** [**ivybridgeyealm.rehab@nhs.net**](mailto:ivybridgeyealm.rehab@nhs.net)  **If your referral is urgent, please telephone Ivybridge Single Point of Contact on: 01752 434908 opt. 3/2** | | | | | | | | |

**PLEASE ENSURE THAT ALL SECTIONS ARE COMPLETED**

**INCOMPLETE REFERRALS WILL BE RETURNED**