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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 KinEthnicity: | 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****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**