**PRESBYTERIAN CHURCH IN IRELAND**

**COUNCIL FOR SOCIAL WITNESS**

**REFERRAL FORM – TRINITY HOUSE**

**Personal Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Referral |  | | | |
| Name of Client |  | | Gender |  |
| DOB of Client |  | | Age |  |
| Client H&SC Number |  | | | |
| Does the Client know about this referral and agree to it? *(Please tick)* | Yes | No | | |

|  |  |
| --- | --- |
| Referring Agent *(persons’ name, designation and location)* |  |
| Referring Agent Contact Number |  |

**GP Details**

|  |  |
| --- | --- |
| GP Surgery |  |
| GP Name |  |
| GP Address |  |
| GP Number |  |

**NOK Details**

|  |  |
| --- | --- |
| NOK Name |  |
| NOK Address |  |
| NOK Contact Details |  |

**Reason for Referral**

|  |  |
| --- | --- |
| **Reason (Primary)** | **Y/N** |
| Decline in physical health |  |
| Dementia/Alzheimer’s |  |
| Personal care needs |  |
| Mobility issues |  |
| Neglect |  |
| Social isolation |  |
| Falls |  |
| Main carer unable to provide carer any longer |  |
| Support with daily living tasks |  |
| Other (please provide details) |  |

**Any other Illnesses**

***(****e.g .mental health and/or key neuro illnesses e.g. Parksinson’s, Alzheimer’s. MS, Pick’s Disease, Huntingtons, etc)*

|  |
| --- |
|  |

**Additional Information**

|  |  |
| --- | --- |
| Does the Client have any particular communication needs? |  |
| Does the Client have a history of falls |  |
| Does the Client use a mobility Aid *(please give details)* |  |
| Are there any safeguarding concerns relating to this Client? |  |
| Does this Client exhibit any behaviours which could challenge *(please give details)* |  |
| Does the client have capacity? *(if no, please provide details, i.e. DoLS restrictions required etc)* |  |

**Further Information**

|  |  |  |
| --- | --- | --- |
|  | Trust | Self-Funding |
| Funding *(tick as appropriate)* |  |  |
| Current location *(own home, respite placement, hospital)* |  | |
| Is immediate/ emergency placement required? *(If yes, please provide details)* |  | |

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| *For office use only*  **Date received:** |