

## Home from Hospital Referral Form (for Islington residents only)

**Important note: shaded areas are essential and a referral cannot proceed without this information. Please also supply further information or attach reports / assessments containing further information where at all possible. Always feel free to call us to discuss referrals on 020 7281 6018.**

<b>Name of client:</b>	<b>Date of Birth:</b>	<b>Age:</b>
<b>Address of client:</b>	<b>Does the client live alone:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>POSTCODE:</b>	<b>Do you consider the client to be vulnerable / at risk?</b> <input type="checkbox"/> Yes (please explain) ..... <input type="checkbox"/> No	
<b>Telephone number:</b>		
<b>Referrer details</b>	<b>Reason for referral</b>	
Date of referral:	<input type="checkbox"/> Routine discharge follow-up	
Name of referrer:	Specific request by referrer ( <i>please state</i> ) ..... ..... ..... .....	
Job title:		
Contact details:		
Referrer's signature:		
<b>Where is the client currently:</b>		
<input type="checkbox"/> In hospital? <i>Which one? Whitt / UCLH / Other</i> <i>Which Ward? .....</i> <input type="checkbox"/> In Intermediate care? <i>Which one? Mildmay / St Pancras</i> <input type="checkbox"/> At home?		
<b>General Practitioner</b>	<b>Relevant medical / surgical history:</b>	
Name:		
Address:		
Phone:		
<b>Community / transport access</b>	<b>Social and informal support networks</b>	
<input type="checkbox"/> Accesses community independently <input type="checkbox"/> Accesses with assistance <input type="checkbox"/> Unable to access currently <input type="checkbox"/> Not known	<input type="checkbox"/> <b>No known friends and family</b> <input type="checkbox"/> <b>Limited friends and family</b> <input type="checkbox"/> <b>Supportive friends / family</b> <input type="checkbox"/> <b>Not known</b>	
<b>Financial situation:</b>	<b>Falls risk</b>	<b>Cryer Score</b>
<input type="checkbox"/> Unknown / uncertain <input type="checkbox"/> Receives DLA / AA / PC / HB / CTB <input type="checkbox"/> Has Taxicard Yes / No <input type="checkbox"/> Energy bills / heating is a problem <input type="checkbox"/> Has grants or other financial assistance? (state) <input type="checkbox"/> Other info:	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> Unknown Other falls information / hazards:	<input type="checkbox"/> CVA/PD? <input type="checkbox"/> Fall last year? <input type="checkbox"/> Balance? <input type="checkbox"/> Sit-to-stand? <input type="checkbox"/> 4+ meds?
		<b>SCORE / 5</b>

**Function, mobility, and leisure (please tick box that most accurately describes situation)**

**Level of daily functioning?**

- Manages all activities independently
- Manages some activities independently, with some activities requiring assistance from carers
- Most activities require assistance from carers / others
- Recives Home care ..... x per day / week       Meals on wheels       Shopping service
- Comment:

**Level of mobility? ('assistance' = assistance or supervision from another person)**

- Mobile without aid or assistance
- Independent indoors, requires assistance outdoors
- Requires assistance indoors and outdoors       Wheelchair user
- Other (please state)

**Leisure interests (please list any known interests and whether the client is able to do them)**

**Home From Hospital Services:**

*(please tick those your clients might benefit from)*

- Falls assessment
- Fire assessment and free alarm
- Security checks and locks
- Minor aids and adaptations\*
- Message in a Bottle
- Telecare assessment referral\*
- Support walking outside
- Support accessing social opportunities
- Rehabilitation assessment\*
- Benefits entitlement check / income maximisation
- Befriending / day centre
- Specific Advice\*
- Health support group referral\*
- Becoming a volunteer
- A helping hand with a specific task\*
- Referral to housing repair service
- Support with housing issues\*
- Financial / debt support

\*Please provide further information:

.....  
 .....  
 .....

**Other professionals or groups involved?**  
*( add name and where based if possible)*

- Social Worker .....
- Occupational Therapist .....
- Physio.....
- District Nurse.....
- Day centre.....
- Befriending.....
- Voluntary organisation.....
- Support group.....

**Person Based?**

**Is there any rehab / toileting equipment on order?**

- Yes
- No
- Unknown

**What's on order?**

**!! URGENT REFERRAL?**

*If this referral is urgent please phone and speak directly to the Home From Hospital team on 020 7281 6018, explaining the urgency*

**Ethnicity**

- English speaking?      Yes      No
- Interpreter required?      Yes      No

**Are there any known or suspected risks associated with staff visiting this client's home alone? Yes No**

**Please explain.....**

**Further information:**

**WHAT TO DO WITH THIS FORM:** you choose! **Fax:** 020 7281 4901 **Post:** Home From Hospital, Age Concern Islington, 6-9 Manor gardens, London N7 6LA, **Tel:** 020 7281 6018 or **email** jessica.bavinton@acislington.org.uk or why not try sending future referrals through **Protocol?**

**Have you attached any important documents or assessments?**