Day Service Referral Form G.O. ID No: ……

Urgency of referral: 2 working days ☐ *Contact within: 5 working days* ☐ *Office use only*

NAME:	Preferred Name:	(PLEASE PRINT) and complete ALL boxes
	Patient Mobile No:	
Address:	Email Address:	
	Belief/Culture	
	Ethnic Origin	
Post Code:	GP Name:	
D.O.B. ……	Practice:	
Age: ……	Tel No:	
Patient Telephone No:	Is GP aware of referral:	Yes No
Mobile No:	CONSULTANTS:	
Marital Status:	NHS Number	

Gender: Male ☐ Female ☐ Non-Binary ☐ Other (prefer not to disclose)

Sexual Identity: Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other

Occupation:

Any Additional Needs required/Identified:

Emergency Contact

Name: **Relationship**

Address:

Telephone No: **Mobile No:**

Does the Patient live alone Yes ☐ No ☐

REFERRAL DETAILS

NAME:	Job Title:	
Date:	Contact No:	

Reason for referral

Day Service Symptom Monitoring ☐ Clinical Support ☐ Carer Support ☐ Social Worker ☐

Fatigue & Breathlessness ☐ Outreach ☐

Complementary Therapy Groups ☐ 1:1 Session ☐

Currently these Services are offered via telephone/online

Emotional & Bereavement Support

Bereavement Support ☐ Counselling ☐ 1:1 Support ☐

Location at referral: Home ☐ Hospital Ward ☐ Other (Please specify) ……

Professionals please email: greatoaks.clinical@nhs.net

Medical Information: (Computer Summary Printout)	**ONLY REQUIRED FOR CLINICAL SUPPORT**
Primary Diagnosis/Date of Diagnosis	
Post/Current Treatment	
Are there any Infection Control issues identified? *Yes* *No* **If yes please specify:** …… …… **Is patient aware of diagnosis / prognosis?** Yes No **Is Next of Kin / Main Carer aware of diagnosis / prognosis?** *Yes* *No* **DNAR Decision /Respect Document:** *Yes* *No*	
Allergies, Drug/Food related. Allergens/Sensitivities:	
Patient aware of referral: *Yes/No*	**Consent to share Medical Information:** IN/OUT

Current problems & specific aims of referral:
1) What has prompted you to refer today? What do you/the person being referred want to get out of being referred to Great Oaks?
2) Are there any physical symptoms?
3) Functional – mobility, activities of daily living - Does the person being referred need support with their functional ability?
4) Social – are there any other professionals involved? Who is their family/social network? Are there any other adults needing support? Are there any financial or housing concerns?
5) Psychological – how is the person feeling? Are there concerns over their mental health/well-being? Does the person being referred have capacity? Are there any suicidal thoughts being expressed?
6) Spiritual – Are they religious or part of a spiritual community? What sustains them at difficult times? Are you aware of any spiritual fears or anxieties?
Any other Support Services involved in Care? (Name and contact details please**)**

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