|  |
| --- |
| Are we the right service to refer to? We try to avoid duplicate referrals where other OT services are already involved, please don’t refer to multiple services which will be providing the same or similar input. If you have referred for rehabilitation, we would be unable to consider permanent adaptations until there is a likely prognosis from the rehabilitation is it is likely to be more appropriate that service completes an onward refer to us as the appropriate time. We do not accept referrals for * Mobility/ Walking aids
* Pressure Care
* Physiotherapy

\*\* Please consider using our online portal which will reduce processing time for the referral. This can be found in the professional’s section of the Live Well Hull Website, along with a copy of this form and other supporting documents you may need. www.livewellhull.org.uk/professional-zone/info-occupational-therapy |
| Name of person being referred |  | DOB |  |
| Home Address |  |
| Temp address if applicable  |  |
| NHS Number |  | Contact Email |  |
| Contact Telephone |  | Emergency Contact |  |
| Property Tenure  | Council/ Private owned/ Private Rented/ Housing Association (please name)  | GP Contact |  |
| Power Of Attorney | Yes/ NoHealth / Finance/ both | Veteran | Yes/No Army/ Navy/ Airforce |
| Ethnicity |  | Religion |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has consent being given for the referral? | Yes/ No | If no consent, is the referral being made in best interest? | Yes/ No |
| Does the person have ongoing care needs | Yes / No | How are these met?  |  |
| Detail Existing Equipment and adaptations  |  |
| Reason for referral- what activities are difficult? - what does the person want to achieve- goals?  | Eg struggling to lift leg into bath, would like to bathe independently |
| What outcome does the person want? Eg stairlift | please note an alternative outcome may be offered if this would meet assessed need |
| How is the person currently managing the difficulty?  |  |
| If you are acting as a trusted assessor- what is your recommendation?  |  |
| Height |  | Weight |  |
| Medical Conditions  |  |
| End of Life or life limiting condition?  | Yes/No | Prognosis if known (for prioritisation)  |  |
| Is there an unmanaged immediate risk of harm to the person or their carer/s? | Yes/ NoPerson/ Carer | Is there an immediate risk of care breakdown?  | Yes/NoFormal/ Informal |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Referrer  |  | Service making referral |  |
| Referrer Contact Telephone |  | Referred contact email  |  |
| Lone Working Risks  |  | Have you attached any supporting information (such as a copy of your assessment) | Yes/ No How many pages? If you are a trusted assessor- have you attached the Spec forms? Yes/ No |