**Single Point of Referral Form**



**Has the person been considered or referred for RRRT? If yes, then there is no need to complete this form. Referrals will be returned if the person hasn’t consented to the referral or if referral has not been completed appropriately.**

**Please send this form to** [**SPOR@Health.gov.je**](mailto:SPOR@Health.gov.je)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CLIENT DETAILS** |  |  |  | |
| **Client Name** |  | **Consent to referral?** | **Yes  No**  **This is required for referral to be accepted unless client is unable to provide consent. If no, give detail:** | |
| **DOB** |  | **URN** |  | |
| **Address** |  | **Telephone** |  | |
| **Lives Alone?** | **Yes  No** | |
| **Next of Kin**  **Name/relationship** |  | **Contact No** |  | |
| **GP name/Surgery** |  | **Contact No** |  | |
| **Cognitive Impairment?** | **Yes  No**  **If yes give detail:** | **Sensory impairment?**  **(hearing/ visual impairment)** | **Yes  No**  **If yes give detail:** | |
| **Care home/package in place? Yes  No**  **Care Provider:** | | **If yes, provide details on placement/package:** | | |
| **REFERRAL DETAILS INCLUDING CURRENT SUPPORT,** | | **CARE NEEDS, MEDICAL HISTORY etc.** | | |
| **Reason for referral, please detail fully:** | | **Relevant/Past medical history/ primary diagnosis**  NB: providing this information will help us to get your referral to the right team/ service: | | |
| **Risk Alerts** i.e. Infection control, essential for Occupational Therapy when providing equipment to clients. Any lone worker risk etc. | |  |
| **Persons expectation of referral:** | | **Is client end of life/palliative or known to Hospice?**  **Yes  No**  **GSF, (if known)**  **RED**  **AMBER**  **GREEN**  **BLUE** | | |
| **SERVICES REQUIRED, please select all required** | |  | | |
| **Adult Mental Health (JAMHS)**  **(under 65)** | | **Older Adult Community Mental Health**  **(Over 65s)** | | |
| **Adult Social Care** | | **Occupational Therapy** | | |
| **Physiotherapy** | | **Psychology** | | |
| **Long Term Care Nursing** | | **Speech and Language Therapy** | | |
| **Learning Disability** | | **Dieticians** | | |
| **Jersey Adult Autism Service** | | **Drug & Alcohol Service** | | |
| **Positive Behaviour Service** | | **Other (please specify)** | | |
| **REFERRER DETAILS** | | **HOSPITAL USE ONLY** | | |
| **Name/relationship:**  **Contact number:**  **Department:**  **Date & Time:** | | **Date of Admission :**  **Estimated Date of Discharge :**  **Ward:**  **Sister/Nurse involved:** | | |

**These details are important to us.**