ISLINGTON

Professional referral form to Social Care and Rehabilitation Team

(Occupational Therapy and Social Services)

Section 1: Referrer details	
Name of referrer	
Profession	
Telephone Number	
Best time to contact	
Email	
Organisation	
Address	

Section 2: Reason for Referral
Please provide brief details for your referral

Section 3: Client details			
Name of Adult			
D.O.B of Adult			
NHS Number		NI number	
Gender		Ethnicity	
Religion		Preferred Language	
Interpreter required?	Yes ☐ No ☐		
Address			
Telephone Number			
GP's Surgery name, address and telephone number			
Carer/NOK Details			
Access Arrangements	Able to open door ☐	Lives with carer ☐	Key safe ☐ If yes, number:
Any known risks to visiting staff?			
Does the person care for someone else? If so, who?	Name		
	DOB:		Phone No:
	Address:		
Accommodation status	Council ☐	Privately Rented ☐	Lodger ☐
	Socially Rented ☐	Privately Owned ☐	Homeless ☐
Has consent been gained to make this referral? Yes ☐ No ☐ ***Please inform client regarding referral prior to sending this form. Only send a referral without consent if there are safeguarding concerns*.**			

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Section 4: Safeguarding

Do you have any Safeguarding concerns?	Yes ☐ No ☐ please go to Section 5

Details

Type of alleged abuse: (tick all relevant)	Financial or material ☐	Sexual ☐	Domestic Violence ☐
	Psychological or emotional ☐	Neglect ☐	Organisational or Institutional ☐
	Modern Slavery ☐	Physical ☐	Self neglect ☐
How did the abuse come to light?	Disclosure ☐	Witnessed ☐	Physical signs ☐
	Other (please specify):		
Date of the alleged abuse:			
Location of the alleged abuse:			

Description of the alleged Abuse:

Information about the person/s causing the alleged harm

	Person 1	Person 2
Name		
Address		
Phone Number		
Gender		
Relationship to adult at risk (Relative/Carer/Etc.)		
Does the alleged perpetrator live with the vulnerable person?		
What action has been taken so far?		
Is there an immediate risk of harm to the victim?	Yes ☐ No ☐ **(If yes you should consider calling 999 or phoning the Access and Advice Service on 020 7527 2299 as appropriate).**	
Is there indication that a crime may have been committed?	Yes ☐ No ☐	
Have the Police been notified?	Yes ☐ No ☐ CAD No if yes:	
Are there any children in the household?	Yes ☐ No ☐	
If yes, have you notified Children and Families?	Yes ☐ No ☐ If children are at risk please call Children's Social Care on 020 7527 7400.	

If yes, record names and ages of children if known	**Name**	**Age**
Details of any known next of kin, friends or neighbours that can help	**Name**	**Telephone Number**
Is the vulnerable person aware of the alert?	Yes ☐ No ☐	
Who else is aware of the alert?		
Does the vulnerable person have the mental capacity to make his / her own decisions with regards to Safeguarding?		
Yes ☐ No ☐ **Details:**		

Section 5:Type of Assessment Required

Social Work ☐	Occupational Therapy ☐

Consent

Is the service user consenting to referral? YES ☐ NO ☐

If not, please explain:

Note: Referrals will NOT be accepted without consent, if a person has capacity to make this decision

Consent for information sharing

Consent for information sharing

Does the service user consent for their personal information to be shared with other professionals?

YES ☐ NO ☐

If not state please explain;

Section 6: Medical Background	
Medical History: (medical conditions)	
Medication and how the person manages	
Recent Hospital Admission: (date/reason)	
Sensory Impairment: (Hearing/Sight/Speech/ Sensory Loss)	
Is the person incontinent?	Yes ☐ No ☐
Incontinent of urine?	Yes ☐ No ☐ Sometimes ☐
Incontinent of faeces?	Yes ☐ No ☐ Sometimes ☐
Using incontinence pads?	Yes ☐ No ☐ Sometimes ☐
Memory Impairment: (memory loss, diagnosis, concerns around mental capacity in particular areas)	

Section 7: Activities of Daily Living		
Does the person you are referring experiencing any difficulties with any of the below?	Yes ☐	Please give details
	No ☐	Please go to Section 8
Washing:	Yes ☐ No ☐	Please give details
Dressing:	Yes ☐ No ☐	Please give details
Eating/Drinking/Nutrition:	Yes ☐ No ☐	Please give details
Meal preparation	Yes ☐ No ☐	Please give details
Shopping	Yes ☐ No ☐	Please give details
Housework	Yes ☐ No ☐	Please give details

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Section 8: Mobility

Does the person you are referring experiencing any difficulties with transfers and/or mobility?			Yes ☐	Please give details
			No ☐	Please go to Section 9
Weight bearing status:				
Transfers	**Independent**	**Assistance Required**	**Needs Support**	**Needs Equipment**
Bed:				
Toilet:				
Chair:				
Bath/Shower:				
Equipment/aids in situ:	Raised toilet seat ☐ Toilet Frame ☐ Commode ☐ Grab Rail ☐ Other (please specify)			
Does the person you are referring have any difficulties accessing the community? Please provide details:				
Indoor mobility aids: (please specify)				
Outdoor mobility aids: (please specify)				

Section 9: Access to and from property

Does the person that you are referring experience any difficulties with access to and from the property?	Yes ☐	Please give details	
	No ☐	Please go to Section 10.	
Negotiating Steps:			
Stairs:			
Ramp:			
Curb:			
Clutter:			
Equipment in situ:	Grab rails ☐ Ramp ☐ Step Rails ☐ Other (please specify):		

Section 10: Falls

Does the person that you are referring experience any difficulties with falls?	Yes ☐	Please give details
	No ☐	Please go to Section 11.
History of falls: (any falls within the last 3 months / location of fall / reason for fall)		
Pendant Alarm	Yes ☐ No ☐ Required ☐	
Telecare Equipment	Yes ☐ No ☐ Required ☐	

Once you have completed the form please send this to the Access and Advice Service using one of the following methods:

Phone	020 7527 2299
Fax	020 7527 5114
Email	access.service@islington.gov.uk
Secure Email	accessservicesecure@islington.gcsx.gov.uk
Address:	Third Floor, 222 Upper Street, Islington, N1 1XR