# Older Person`s Clinic Referral

## Patient details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name: |  |  |  M [ ]  |  F[ ]  |
|  | Name | Surname  |  Gender |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  | DOB | NHS No |

|  |  |  |  |
| --- | --- | --- | --- |
| Address: |  | London  |  |
|  | House No and Street | City | Post Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

## Additional information

|  |  |  |
| --- | --- | --- |
| Has patient agreed to this referral? | YES[ ]  | NO[ ]   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Background: |  |  |  Y [ ]  |  N[ ]  |
|  | Ethnicity | Language  | Interpreter needed? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| NOK: |  |   |  |
|  | Name | Relationship | Best contact number |

|  |  |  |  |
| --- | --- | --- | --- |
| Risk to others? |  YES [ ]   | NO[ ]   | Details: |
|  |  |  |  |
| Does Pt need hospital transport? |  YES [ ]   | NO[ ]   | If so, please inform patient they will need to book the transportvia phone tel. 03300 416 767 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| GP: |  |  |  Y [ ]   |  N[ ]  |
|  | Name | Name of GP surgery  |  Have you informed GP been about this referral? |  |

## Reason for the referral

**Current concerns.** Identified problems and what would you like us to provide? If possible, we would be grateful if you could include history of your patient’s difficulties, duration & diagnosis.

**Past medical history:**

What assessments and treatments have been done so far? (cognitive assessment, postural hypotension test etc.)

## Referrer`s details

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Job Title: |  |
| E-mail: |  | Phone: |  |
| ELFT Team: |  |  |  |

|  |  |  |
| --- | --- | --- |
| Have you informed your supervisor about this referral? |  YES [ ]   | NO[ ]   |
| Sign: |  | Date: |  |

Please send the referral to: bhnt.opc@nhs.net

Please refer patients who: · Are a Tower Hamlets Resident · Aged over 65 years · Would benefit from a combined Comprehensive Geriatric/ mental health/ therapy assessment

Please DO NOT refer patients who: · Have a specialty problem · Require admission