|  |
| --- |
| Community Occupational Therapy Referral |

PLEASE COMPLETE **FULLY** IN ORDER TO PROCESS YOUR REFERRAL

**Locality: Email completed forms to or see postal address at the end:**

* Downpatrick [downpatrick.communityot@setrust.hscni.net](mailto:Email:%20downpatrick.communityot@setrust.hscni.net)
* Lisburn [lisburn.communityot@setrust.hscni.net](mailto:lisburn.communityot@setrust.hscni.net)
* North Down and Ards [community.ot@setrust.hscni.net](mailto:community.ot@setrust.hscni.net)

|  |
| --- |
| Surname: Forename: Mr / Mrs / Miss / Ms |
| **Address:** |
| **Post Code: Tel No: Mobile:** |
| Previous Address**:** |
| **Date of birth:H&C No (if known):** |
| **GP Name:** |
| **Address:** |
| Are there any other Professionals involved? Yes: **** No: **** |
| Care Manager involved? Yes: **** No: **** |

|  |
| --- |
| **Primary Diagnosis:** |
| **Relevant Medical History (including psychiatric history)** |

|  |
| --- |
| Please identify the problems experienced and reason for referral: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ****  ****  ****  **** | **Home situation: (Please tick)**  Lives alone  Lives with other elderly person(s)  Lives with other disabled person(s)  Lives with able-bodied family members | |  |  |
| Name of Main Carer: | | Tel: | | |
| Next of Kin: | | Tel: | | |
|  | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Ownership: |  |  |  |
| **** NIHE  **House Type:**  **** Flat GroundFlat **** Flat 1st Floor  **** Flat Other Floor | **** Housing Association    **** Bungalow  **** Two Storey | **** Privately owned | **** Privately Rented  Bedroom 🡻⇧ Bathroom 🡻⇧Toilet 🡻⇧ |

|  |
| --- |
| Is there anything we need to know before we visit your property? Yes  specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No   ***CAN CLIENT ATTEND ASSESSMENT CLINIC?*** *Yes:*    *No:*   \*  *\* If no please state reason.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
|  |
| Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Relationship (if appropriate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you are making a referral on behalf of someone does the Client consent to referral?Yes  No  Date: \_\_\_\_\_\_\_\_\_\_\_ |

**Return completed forms to the relevant office below:**

**DOWNPATRICK:** Community Occupational Therapy Department, Disability Resource Centre, Downshire Hospital, Downpatrick, BT306RA or by email to [downpatrick.communityot@setrust.hscni.net](mailto:Email:%20downpatrick.communityot@setrust.hscni.net)

**LISBURN**: Community Occupational Therapy Department, Lisburn Health Centre, Linenhall Street, Lisburn BT28 1LU or by email to [lisburn.communityot@setrust.hscni.net](mailto:lisburn.communityot@setrust.hscni.net)

**NORTH DOWN & ARDS:** Community Occupational Therapy Department, Administrative Offices, Newtownards Road, Bangor, BT20 4LB or by email to [community.ot@setrust.hscni.net](mailto:community.ot@setrust.hscni.net)