**Integrated Care Centre – Frailty Support Team (ICC - FST) Comprehensive Geriatric Assessment**

**Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

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| Name of Referrer:  | Date of Referral:  |
| Job Title:  |
| Address & contact number/email of referrer:  |
| **PATIENT DETAILS** |
| Registered GP:  | GP Practice Address:  |
| Title:  | Forename:  | Surname:  | Known as:  |
| Date of Birth:  | NHS Number:  |
| Gender: | Ethnicity: |
| Religion: |
| Address:  |
| Patient home number:  | Patient mobile number: |
| Preferred contact number: Home [ ]  Mobile [ ]   | Email address: |
| Lives alone/carers/nursing home/residential home: | Next of Kin/Carer/Emergency contact: |
| Consent to contact via SMS | Yes [ ]  | No [ ]  |
| Consent to contact via Email  | Yes [ ]  | No [ ]  |
| Consent to share medical information:  | Yes [ ]  | No [ ]  |
| Translator required: | Yes [ ]   | No [ ]  | Language required\*: |
| Chaperone required: | Yes [ ]   | No [ ]  |
| Accessible information needs:  | Yes [ ]   | No [ ]   | Detail needs: |
| Diagnosis:  | Client aware of diagnosis?  | Yes [ ]  | No [ ]  |
| Are there any other services involved in patient’s care | Yes [ ]   |  No [ ]  | Don’t know [ ]  | **(If yes give details)** |
| **SUPPORTING INFORMATION** |
| Is there a Lone working risk?  | Yes [ ]  | No [ ]  |
| Is there a Safeguarding risk?  | Yes [ ]  | No [ ]  |
| Has the patient given consent for the referral?  | Yes [ ]  | No [ ]  |
| Any concerns re Mental Capacity?  | Yes [ ]  | No [ ]  |
| **ReSPECT** document in place?  | Yes [ ]   |  No [ ]  | **(If yes give details)** |
| Smoking: | Yes [ ]   |  No [ ]  | Don’t know [ ]  |
| **REFFERAL DETAILS**  |
| **(Please outline details for referral)** |
| **eFI score ( if not known please specify CFS):**  |
| **Referral/eligibility criteria:**Severely frail (**eFI Score** > 0.36) or Moderately frail (**eFI Score**  0.25 – 0.36) with at least one of the following eligibility criteria:- living in sheltered housing, Dementia, age over 90 or Palliative* Patients MUST be registered with a Hull GP
* Not living in residential/nursing care (please see separate care home pathway/referral form)
* Patients must consent to referral
* Electronic record sharing will need to be in place at the time of referral
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\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***