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**STAFFORD LAP REFERRAL FORM**

**Tel: 0300 124 0343**

**Email:** **StaffordLAP@mpft.nhs.uk**

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| **\*Referral Date and Time:** Click here to enter a date. | **\*Referrer details; Name & telephone number:**(e.g. hospital/ward/clinic/carer/relative)      |
| **\*Referral for: (select as appropriate)**District Nurse[ ]  Social Care[ ]  CIS Nurse[ ]  CIS CPN[ ]  Physiotherapy[ ]  Occupational Therapy[ ]  CIS ANP [ ]  ROVI [ ]  ROHI [ ]  |
| **\*PATIENT DETAILS**Name:     Preferred Name:      DOB:      NHS Number:       | **\*NOK Details:**     **\*GP Practice:**      |
| **\*ADDRESS TO VISIT:**      Telephone Number:     Access details (keysafe):     Will the patient be able to get to the door?*Select Y/N* | **\*Home Address** (If different from address to visit)       |
| **HOSPITAL REFERRAL (for DNs / CIS / OT/Physio)**Date of Admission: *Click here to enter a date.*Date of Discharge:*Click here to enter a date.*Date of first visit required:*Click here to enter a date.*Reason for Admission:      Discharge Letter/Summary information attached? *Select Y/N* |
| **Is the patient able to attend a Clinic/ Practice Nurse?** *Select Y/N*\*Please ensure ONLY Housebound patients are referred to the District Nurses, alternatively please ensure the patient is aware to make an appointment with their Practice Nurse \* |
| **If Referral is for Social Care – is patient aware of the referral?** *Select Y/N*.**If no – briefly explain why:** |
| **REASON FOR REFERRAL/VISIT** *(please also include current mobility, longstanding health conditions etc)*      |