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**STAFFORD LAP REFERRAL FORM**

**Tel: 0300 124 0343**

**Email:** [**StaffordLAP@mpft.nhs.uk**](mailto: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)* | |