Link Visiting Swanage - Referral Form

1. Basic Information

Name: _____

Preferred name: _____

Date of Birth (dd/mm/yyyy): _____ Gender: _____

Address: _____

Town: Swanage_____ Postcode: _____

Accommodation: _____

Hints on finding the address:
(if difficult)

Contact No (H):_____ (M) _____

Name of GP: _____ GP No: _____

Name of GP Practice: _____

First Emergency Contact: _____ Tel No: _____

Second Emergency Contact: _____ Tel No: _____

Next of Kin: _____ Tel No: _____

2. Other Information

Relevant Medical History:
(Continue on A4 sheet if not enough space)

Reason for Referral:

Does the client suffer from short term memory loss? (Has there been a diagnosis?)

Name of Social Worker: _____

Is there a Personal Care Budget: Yes / No

If Yes, does it cover Social isolation: Yes / No

Are there any communication difficulties?

Suggestions for activities?

3. Person Referring

Name: _____

Agency/Organisation/

Relationship to person referred: _____

How long have you known the person referred? _____

Contact No: _____

Email: _____

The person referred has agreed to this referral

Signed: _____ Referral Date: _____

Data Protection Statement

Please note that all information contained within this document will be stored and utilised within the guidelines of GDPR regulations and – where necessary - the appropriate consent will be obtained from those about whom we hold information.

Once completed, please return this document to:

Link Visiting Swanage
21 Commercial Road
Swanage BH19 1DF
e-mail: swanage@linkinglives.uk **Tel. No.** 07495 534171