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

**Referral Form**

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

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | | | | |

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***