|  |  |  |  |
| --- | --- | --- | --- |
| **Client Details** | | | |
| **Client Name:** |  | | |
| **Address:** |  | | |
| **Date of Birth:** |  | **Contact Number:** |  |
| **GP Name:** |  | **GP Address:** |  |
| **NOK Details:** |  | | |
| **NHS Number (if known and available)** |  | | |
| **Ethnicity:** |  | **Religion:** |  |
| **Is Client aware of Referral / has client given consent?** | Yes: No:  | | |
| **Reason for Referral:** |  | | |
| **Is COT intervention essential to enable hospital discharge** |  | | |
| **Medical history RELEVANT to current situation** |  | | |
| **Mobility Inside / Outside** |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How do you attend GP appointments (independently/with support, do they walk, get bus, taxi, drive)** |  | | | |
| **Accommodation** | | | | |
| **Ownership – Owner / Housing Association / Private Landlord** |  | | | |
| **Layout of property (location of toilets, number of ground floor rooms)** |  | | | |
| **Access to property / need to go out (type, ability to manage, how often goes out)** |  | | | |
| **Stairs (rails, stair lift, how manages to use)** |  | | | |
| **Transfers** |  | | | |
| **Toilet (continence, transfers, any equipment in place)** |  | | | |
| **Bed (type, legs, how transfers)** |  | | | |
| **Armchair or sofa (type, legs, how transfers)** |  | | | |
| **Bath and or shower (type of bath/shower)** |  | | | |
|  |  | | | |
|  |  | | | |
| **Self-Care** |  | | | |
| **Ability to wash at basin fully and independently – back / feet / hair** |  | | | |
| **Household Tasks** |  | | | |
| **Domestic Tasks, (Meals, shopping, cleaning)** |  | | | |
| **Referrer Name:** |  | **Contact Number:** |  | |
| **Signature:** |  | **Department:** |  | |
|  |  | | | |
| **Please fax completed form to 01296 387843 alternatively email to**  [**crr@buckscc.gov.uk**](mailto:crr@buckscc.gov.uk) | | | |  |