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| --- | --- | --- | --- | --- | --- |
| **Patient Name:** | | | **NHS Number:** | | **DoB:** |
| **Address** | | | **Telephone No:** | | **Ethnicity:** |
| **Carer/NOK Name:** | | **Carer/ NOK Contact Details:** | | **Does the patient require an Interpreter? Yes/No**  **If yes, which language:** | |
| **GP Details: GP Telephone No:**  **GP Practice:** | | | | | |
| **Has the patient consented to referral/treatment? Yes/No**  **Has the patient consented for service to access information relevant to this referral? Yes/No** | | | | | |
| **Has consent been given to talk to anyone directly involved in your care? the patient’s carer/relatives in relation to the care? Yes/No** | | | | | |
| **Neurological Diagnosis (including any relevant medical history and dates):**  **Is the patient aware of their diagnosis? Yes/No** | | | | | |
| **Which LTNC Service do you feel is required? Please see info**  **Neuro Case Management NES SCBIRT** | | | | | |
| **Are there any services already involved with this patient, If so please provide relevant details:** | | | | | |
| **Name** | **Profession** | | **Location** | | **Contact Number** |
|  |  | |  | |  |
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| **Reason for Referral (including presenting problem/s and patient aim(s) ):** | | | | | |
| **Is there evidence that the person is having difficulties relating to:**    **Falls Dysphagia please give brief details for falls/dysphagia Following a minor head injury**  **Is this the reason for referral?**  **Note to RPU - If YES complete questionnaires at Referral / Triage** | | | | | |
| **Medication:**  **Relevant Investigations / Scan Results:** | | | | | |
| **Social Situation:** | | | | | |
| **As per SHSC guidelines, it would be helpful if you could complete the information below in order for us to proceed with the referral efficiently. Thank you.** | | | | | |
| **RISK OF HARM TO OTHERS?** (Consider severity, likelihood, imminence)   * Previous known history * Poor impulse control * Recurrence of past risk circumstances * Threats to harm others * Any known police or court involvement * Use or access to weapons | | * **Risk to others** * **No risk to others** * **Risk not ascertained**–   If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **RISK OF HARM TO SELF? (Consider severity, likelihood, imminence)**   * Continuing risk * Previous attempts * History of attempts of suicide * Continuing suicidal intent * Use or access to weapons | | **❑ Risk to self**  **❑ No risk to self**  **❑ Risk not ascertained**  If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **RISK OF SELF-NEGLECT? (Consider severity, likelihood, imminence)**   * Current self-neglect (eg hygiene, appearance, surroundings, injuries) * Previous history of self-neglect | | **❑ Risk to self**  **❑ No risk to self**  **❑ Risk not ascertained**  If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **RISK OF EXPLOITATION OF SERVICE USER? (Consider severity, likelihood, imminence)**   * **(Safeguarding adults)**Financial * *Sexual* * *Physical* * *Other* * *Previous* history of exploitation * *Ongoing proceedings* | | **❑ At risk of exploitation**  **❑ No risk of exploitation**  **❑ Risk not ascertained**  If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **RISK TO DEPENDANTS?** (Consider severity, likelihood, imminence)   * *Ongoing proceedings (eg Safeguarding Children)* * *Care or Safeguarding issues* * *Previous history of risk to dependants* * *Regular contact with children* * *Children in household/carer/contact with children (Gender, Age, eg M, 6 yrs)* | | **❑ Risk to dependants**  **❑ No risk to dependants**  **❑ Risk not ascertained**  If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **RISK TO CARERS? (Consider severity, likelihood, imminence)**   * **Carer stress** * **Risk from manual handling** * **Care package/placement breakdown** | | **❑ Risk to carers**  **❑ No risk to carers**  **❑ Risk not ascertained**  If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **Other, eg Drug/Alcohol Misuse:** | | **❑ Yes**  **❑ No**  **❑ Not ascertained**  If ‘YES’, please describe the identified risk and describe the safety plan. | | | |
| **Referrer:**  **Date completed:** | | **Designation:**  **Team & Base:** | | **Team Telephone Number:**  **Mobile Number:** | |