**Hospital & Community Navigation Service Referral Form**

**Please save and e-mail this form to:**

**Hospital or Community Based Referral – Herts Valleys:** west@herts.help

**Hospital or Community Based Referral – East & North Herts:** eastandnorth@herts.help

**If you have an urgent query about a referral that requires a same day response call: 0300 3031547. For all other enquiries and updates please use the above email addresses.**

|  |  |
| --- | --- |
| **Has the person given their consent for this referral to be made?**  | **Yes / No** |

**Referrer Details:**

|  |  |
| --- | --- |
| **Date of Referral:**  | **Email:** |
| **Name of Referrer:**  | **Position/Title:** |
| **Name of Organisation:** | **Contact number:**  |
| **Name of Hospital *(If applicable*):**  | **Ward:** |
| **Reason for (and date of) admission:** | **Date of Discharge:** |

## **Information about the Person being referred:**

|  |  |
| --- | --- |
| **Name:** **Title: (Mrs/Mr/Ms/Miss)** | **NHS Number:**  |
| **Gender:**  | **Date of Birth:**  |
| **Disability:** | **Ethnicity:**  |
| **Communication Needs:** | **Religion:** |
| **Address:** **Telephone:** |
| **Next of Kin:** **Telephone No:** | **Relationship:**  |
| **GP Surgery:****GP Telephone:** | **GP Address:**  |
| **Does the person live alone?**  | **Yes** | **No**  | **Details:**  |
| **Is this person a carer?** | **Yes** | **No** | **Details:** |
| **Is this person a veteran?** | **Yes** | **No** | **Details:** |
| **Relevant Medical History:** |  |
| **Other agencies involved**:  |

|  |
| --- |
| **Any known Risk Factors – *Please Answer Yes or No and provide details*** |
|  | **Yes** | **No** | **Details** |
| **Can the person be visited alone?** |  |  |  |
| **Does the person live alone?** |  |  |  |
| **Drug or alcohol dependency?**  |  |  |  |
| **Offending/aggressive behaviour?** |  |  |  |
| **Any pets in the home?** |  |  |  |
| **Is this person a smoker?** |  |  |  |
| **Other details:** |
| **Would you like to receive feedback about this person?** | **Yes / No** |
| **Reason for referral & required outcome:****Form Completed By:** |