

**Lanfine Service**

**Referral Form**

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| --- | --- |
| **Name:****Address:****Telephone:** | **DOB:** |
| CHI No:  |
| **Gender:** |

PRESENTING CONDITION:

|  |  |
| --- | --- |
| **Diagnosis:** | **Date of Onset:** |
| **Relevant Medical History:** |

**REASON FOR REFERRAL:**

BACKGROUND INFORMATION:

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|  |

CARE GIVER CONTACT:

|  |  |
| --- | --- |
| **Name: Relationship to Service User:** | **GP Details:** |
| **Address:** | **Other key contacts:** |
| **Tel No.** |

**Other Agencies Currently/Recently Involved (name, role, contact details)**

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QUESTIONS:

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| Is the person aware of this referral? Y/NDoes the person consent to information sharing – carer or carer named overleaf. Y/NDoes the person consent to information sharing – other agencies involved. Y/NAre there any spiritual, religious or cultural matters relevant to the provision of Service? Y/NIf yes please detail: Is there any reason why a lone worker should not visit this household? Y/NIf yes, please detail:Could this person attend an outpatient clinic? Y/NDoes this person require a translator? Y/NIf yes which language? |

REFERRER DETAILS:

|  |  |  |
| --- | --- | --- |
| Name of Referrer: | Designation: | Date of Referral: |
| Address:  |
| Tel No:  |
| Email: |

**If you would like to discuss a potential referral before sending it, please ring 0131 5379087**

**Please return completed form to: Pauline Zavaroni , Lanfine Team Administrator, East Pavilion, Astley Ainslie Hospital, Grange Loan, Edinburgh, EH9 2HL**

**or email to** Lanfineservice@nhslothian.scot.nhs.uk

**The Lanfine team meets weekly to review all new referrals.**