ORLAU New Referral Form

***Referring clinician:*** (Please complete in full if external)

|  |  |
| --- | --- |
| Clinician Name: | Job Title: |
| Date of Referral: | Tel No: |
| Clinician Address: | Email Address: |
| Referring signature: |
| Is patient aware of reason for referral: Yes / No  |

***Client Details:*** *(Please complete in full)*

|  |  |
| --- | --- |
| Client Name: | NHS No: |
| D.o.B: | Tel No: |
| Home Address: | Preferred pronoun: |
| Preferred method of contact: |
| E-mail address (if known): |
| Any known safeguarding concerns? |

***Parent/Guardian/Carer contact details:*** *(Please complete in full as applicable)*

|  |  |
| --- | --- |
| Parent/Guardian/ Carer Name: | Tel No:  |
| Address: (if different to above) | Mobile No: |
| Relationship: |

***Requirements for appointment:***

|  |  |
| --- | --- |
| Interpreter required? Yes / No  | Language required: |
| Mobility status:  | Specialist equipment required for appointment: (please circle) *Hoist / Wide couch / Parallel bars / Stretcher*Other: (Please specify) |

***Current complaint and Status:*** *(Please complete as appropriate)*

|  |
| --- |
| Primary Diagnosis: |
| Referral Question: |
| Current complaints & status: (Please give brief overview) |
| Relevant Past medical History: (Epilepsy, Diabetes etc..) |

*Please send completed forms to* *rjah.orlaureferrals@nhs.net*

*Please don’t hesitate to contact us if you have any problems filling out the form – 01691 404532*