Primrose Day Centre Referral Form

Name:
Address:

Date of Birth:
Date of Referral
Start Date

Tel Number:
Key Safe number:

Referrer Name:

Relationship to client:

Tel number:
Reason for referral:

Next of kin:
Address

Emergency daytime contact:

Name and Address of Power of Attorney (if applicable)
Well Being
Financial
Both

GP:

Surgery:
Tel number:

Dietary requirements/food allergies

Health

Please list all medical conditions including any medical allergies
Diabetes – Yes/No

Dementia – Yes/No
Any other health issues e.g. heart, stroke, blood pressure

Is prompting required to take medication? Yes/No

Other services
Home care Yes/No
Date and times
Care Agency Provider

District nurse Yes/No
Frozen meals Yes/No

Care Manager Yes/No
Name and contact details

Aids – glasses/hearing aid/special cutlery/stick/walking frame/wheelchair/other

If aids used, please state frequency e.g. uses a wheelchair for longer distances only

Personal Care

Is assistance required with toileting/eating/memory/communication/ mood?
If yes to any of the above, or other supports required, please state

Home Circumstances
Lives alone Yes/No
Lives with

Type of accommodation – Upstairs flat/ground floor flat/bungalow/house

Bathroom – upstairs/downstairs
Bedroom – upstairs/downstairs

Personal History

Family, previous occupation, hobbies/interests, likes/dislikes.

Please give information regarding the person's "life story" – for example names of children, birthplace, work history, hobbies etc. this knowledge helps staff to enable clients (especially those with a degree of confusion) to settle into the centre. Please use the space below and add a continuation sheet if needed!

Consent to sharing information.
Information above will be treated confidentially. There may be occasions (for medical reasons or other emergencies) when this information may need to be passed to other agencies.

I …… consent/do not consent to my details being shared with other agencies in an emergency or matters of safety.