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| **Wellbeing Enterprises CIC****Adult Referral Form – Wellbeing Review service** |
| **1. PERSON DETAILS (Please complete one referral form per patient, we cannot accept one referral for a couple for safeguarding reasons).****Does the person referred live in:**

|  |  |
| --- | --- |
| [ ]  Halton | [ ]  St Helens |

**Does the person referred require a home visit?**

|  |  |
| --- | --- |
| [ ]  Yes | [ ]  No |

**Does the person referred require a Primary Care Navigators Wellbeing Review for dementia?**

|  |  |
| --- | --- |
| [ ]  Yes | [ ]  No |

|  |  |
| --- | --- |
| **Name:** |  |
| **Address (including postcode):** |  |
| **Date of Birth:** |  |
| **Contact number:** |  |
| **GP Practice registered with:** |  |

**Please complete the following information with as much detail as possible.**

|  |  |
| --- | --- |
| **Reason for referral (e.g. what would the person like or benefit from?)** | . |
| **Does the person have a history of mental health issues, substance misuse or offending behaviour?** |  |
| **Does the person have a learning disability or any physical impairments?** |  |
| **Does the person have any involvement with any other statutory services (e.g. social care or probation?)** |  |
| **Any other relevant information** |  |

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| **2. REFERER DETAILS**

|  |  |
| --- | --- |
| **Name:** |  |
| **Organisation:** |  |
| **Organisation address (including postcode):** |  |
| **Contact number:** |  |
| **E-mail address:** |  |

**3. Risks****Potential risks****Are you aware of any potential risks we may need to be aware of to deliver this service to the individual? (Persons behaviour, state of property, location, pets etc.)****Yes / No** **If yes please give more details** *...…………………………………………………………………………………………………………**…………………………………………………………………………………………………………...**……………………………………………………………………………………………………………***Potential Safeguarding Issues****Are you aware of any safeguarding issues that are relevant to this referral?****Yes / No****If yes, have they been referred to a social care safeguarding officer?** **Yes / No****If yes to either question, please give more details:***………………………………………………………………………………………………………………**………………………………………………………………………………………………………………**………………………………………………………………………………………………………………* |
| **3. DECLARATION****Has the person referred given consent for this referral and for Wellbeing Enterprises to contact them via telephone?**

|  |  |
| --- | --- |
| [ ]  Yes | [ ]  No |

|  |  |
| --- | --- |
| **Signed:** |  |
| **Date:** |  |

 |
| **Please return this completed form by:*** **Emailing it to** **wellbeing.enterprises@nhs.net**
* **Fax it to 01928 551 922**
* **Posting to Wellbeing Enterprises CIC, Bridgewater House, Old Coach Road, Runcorn, Cheshire, WA7 1QT**

**We will acknowledge your referral with a reply within two working days, and then contact you again once we have made contact with the person referred.**INTERNAL USE ONLY

|  |  |  |  |
| --- | --- | --- | --- |
| Date referral received: |  | Approved by: |  |
| Home visit approved: | Yes No | Date approved: |  |

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