Support at Home Referral Form

BRC USE ONLY	Date received:		Time received:		BRC Ref:		CAS-
Referral taken by: ☐ phone ☐ email ☐ f2f				Allocated to:			

Referring organisation:		Name of person making referral:	
Form completed by (if different):		Contact number:	
Referral source:	☐ A&E ☐ Discharge Lounge ☐ Community ☐ Self Ref ☐ Charity ☐ Other: ☐ Ward ☐ GP ☐ Social Services ☐ Family / Friend ☐ Internal (BRC)		

Service Eligibility *If the referral is not eligible you will not need to complete the remainder of the form*

To be eligible for this service the person must:

1. NOT have had any infectious diseases still considered to be within a transmissible period e.g. C-diff / CMV / Norovirus

Do you confirm that the person meets the eligibility criteria?	

Consent - NB: We cannot take the referral without consent

Has the person agreed to the referral & their personal data being passed to British Red Cross?	
Or, if they are unable to consent has a best interest or 'benefit decision' been made?	

Date of consent: (Date obtained or of benefit decision)		If best interest / benefit decision, name of person making decision:	

Person's Details

Name:		Gender:		DOB:	
Preferred Name:		Pronouns:		DNAR in place?	
Preferred language:		NHS no.			

Reason for Referral

Select all that apply: ☐ Shopping ☐ Key safe ☐ Transport ☐ Befriending ☐ Pendant alarm ☐ Other:	Notes:

In relation to supporting this person is there anything that we should be aware of?

Drug Dependency		Alcohol Dependency		Details:
Violent Behaviour		Behaviours that challenge		
Mental health		Lone working		
Other:				

Do you have any safeguarding concerns in relation to this referral?	

Details:

Communication

Hearing	☐ Fine ☐ Limited	*Details:*
Vision	☐ Fine ☐ Limited	
Speech	☐ Fine ☐ Limited	

BRC Ref:

Home & Accommodation Details

Address:		Mobile:		Key safe?	
	Postcode:	Landline:		Do they know the code?	
Is this address temporary?		Property type:	☐ House ☐ Bungalow ☐ Flat ☐ Other:		
Are they a carer?		Living arrangements:	☐ With spouse/partner ☐ Nursing/Care Home ☐ No fixed abode ☐ Living alone ☐ With other family/friends ☐ Sheltered accomm. ☐ Other:		
Property access issues? e.g. steps, lift, parking		Pets?			

Emergency Contact

Name:		Relationship to person:	
Consent to contact?		Tel No:	

Hospital Referrals (Please leave blank if you are not referring from a hospital setting)

Reason for admission / attendance:		Date of admission / attendance:	
		Date of discharge:	

Will the referral contribute to any of the following? (Select all that apply – to be completed by referrer)

☐ Quicker discharge ☐ Prevent a hospital admission ☐ Prevent a delayed transfer of care
☐ Safer discharge ☐ Reduce length of stay ☐ Help prevent breach of the 4-hour standard of A&E

Medical & Health

Is this person on a Virtual Ward?		History of falls?		Do they smoke?	
Any known allergies?		Any other relevant medical history? e.g. dementia			

If yes provide details:

GP Surgery:

Care Arrangements & Other Services

Is there a care package in place?		Name of provider:	
Details of care package: *(frequency etc)*		Contact number:	
Other services engaged with the person:			

Additional notes / information from referrer:

BRC USE – Notes / Comments:

BRC USE - Reason for Cancellation / Decline						
1 Taken by PTS	**2** Taken by relative/friend	**3** Taken by Taxi	**4** Does not fit criteria	**5** Failed / No Discharge	**6** Canx by Hospital	**7** - Other (specify)
☐	☐	☐	☐	☐	☐	

Date input / scanned to BRM: