|  |  |
| --- | --- |
| **To:**  Community Health & Wellbeing Service  Spencer House  Dewhurst Rd  Birchwood  WA3 7PG | **From:**  Sender / Organisation Details  Sender Address  Tel:  Email: |

**Date:**

**Referral Criteria for: Warrington Community Health & Wellbeing Service**

**Please complete all sections below, including the reason for this referral. Email to the service at:**[warr.chw@nhs.net](mailto:warr.chw@nhs.net).

**Section A: Demographic Details for the Patient:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Surname/Family name:** | | | | | **First Name:** | |
| **Gender**:  Other *(specify):*  Preferred Name/Pronouns (If different to above): | | | | | | **Date of Birth:**  **Age:** |
| **Address:** | <Patient Address> | | | | | |
| **NHS Number (***if known***):** | | | | **Patient Contact Details:** | | |
| **Ethnicity:** | | | | **Preferred Language:**  Interpreter Needed?  Yes  No | | |
| **Marital Status:**  Single  Married  Separated  Divorced  Widowed  Civil Partnership  Other (Specify) | | | | | | |
| **Religion:** | | | | | **Military Veteran**  Yes  No | |
| **GP Details:** | | | | | | |
| **Next of Kin:** | | | | | | |
| **If patient is under 16, please complete the following:** | | | | | | |
| **Who has parental responsibility for the child?** | | |  | | | |
| **Relationship of primary carer with child** | | |  | | | |
| **Details of school/establishment (including home school/nursery)** | | | | | | |
| **Occupation/ Employment Status:** | |  | | | | |

**Section B: Access Support Needs our Service:**

|  |
| --- |
| **Tick here if this section is Not Applicable to this patient**: **Go direct to section C of this form >>** |
| **Please provide information of any specific support needs for this person to access the service. Identify any reasonable adjustments required.**  For example: Wheelchair access, BSL, Makaton or other language interpretation; easy read or large print information; longer appointment time; carer or advocacy support, including mental health needs or caring responsibilities. |
|  |
| **Has the person consented to the referral?**  **Yes  No** |
| **Any other supporting information:** |
|  |

**Section C: Reason for referral to service:**

Enter either N/A or provide as much information regarding the issue and/or needs for support in each of the following sections:

|  |  |
| --- | --- |
| **Health** |  |
| **Lifestyle** |  |
| **Housing** |  |
| **Social** |  |
| **Other** |  |

**Name of Referrer:**

**Designation:**

**Tel:**

**Email**: