|  |  |
| --- | --- |
| **To:**Community Health & Wellbeing ServiceSpencer HouseDewhurst RdBirchwoodWA3 7PG | **From:**Sender / Organisation DetailsSender AddressTel: 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.

**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**: