Reference No: ……………

AGE CONCERN MAIDSTONE
REFERRAL FORM FOR DAY CARE/BATHING/FOOTCARE

1.

Form filled out by:		Date referred:
Source of referral:	Tel:	Funding: 1. Social Service 2. Self 3. Other

Title:	Forenames:	Surname:	Marital status:
Address:		Postcode: Tel: Mobile:	D.O.B.

Lives with (eg.partner, alone):	Accommodation: Private / Housing Trust	Warden & Tel:
Life Line/Pull Cord contact:	Box Key Safe: Yes / No	SPARE BOX

Next of Kin Name:	Address:	Tel:	Relationship:
Next of Kin Name:	Address:	Tel:	Relationship:
Keyholder/s Name:	Address:	Tel:	Relationship:

Doctor:	Address:	Tel:

District Nurse	Tel:
Care Manager:	Tel:
Other:	Tel:

2. MEDICAL HISTORY: MEDICATION:

MEDICAL HISTORY	MEDICATION
ALLERGIES:	

IMPAIRMANTS:	Reason/right/left/aids:
Speech:	
Sight:	
Hearing:	
Memory Loss:	

3. DIETARY NOTES: OTHER SERVICES:

DIETARY NOTES		OTHER SERVICES	
Normal		Meals delivered Company & day/s del.	
Fat Free		Domestic Help Company & day/s	
Diabetic		Personal Care Company & day/s	
Vegetarian		Benefits What type?	
Ethnic		Aids (eg.walking stick)	
Food problems ie fish,beef,vegs		Mobility (eg.good, average,poor,unsteady):	
Food allergies			

4. CRITERIA: Dependency Level

High	Medium	Low
Other relevant information		

5. BATH TYPE (Please tick)

Bath		Shower		Bath Mat		Hot water			
Needs help: Getting into bath				To dry just back/feet & legs					
Getting into water				To get into underwear					
To dry completely				To dress completely					

6. FOOTCARE – Other relevant information (Please tick boxed)

1. Special Needs		4. Steroids 5 mgs -			
2. Diabetes: N.I.D. I.D.D.		5. Client receiving chiropody at time of referral			
3. Anticoagulants		6. If yes: Private:		N.H.S.	

Podiatry referral requested	Client:		Nurse:	
Waiting list:			Clinic:		Dom:	

7. RISK ASSESEMENT OF MAIN RISKS IDENTIFIED

eg Access to Home:			
Pets:			

8. NOTES:

Domiciliary Visit:
Clinic Visit:

9. DESIGNATED NURSE

BATHING		Date client commenced	
FOOTCARE		Date client commenced	
Reasons for refusal:			

10. TRANSPORT:

Walker	Minibus	Car	Taxi	Vol.Bureau	Scooter
DAY CENTRE/S TO ATTEND:				START DATE:	

Signature of visiting Manager/Supervisor/Nurse: ________________

Date: _______________

Sections 1,2,3,4,7,8,9 to be completed by all visiting staff
Section 5 – Bath Service
Section 6 – Footcare
Section 10 – Day Care
To be signed and dated by Manager/Supervisor/Nurse