

Oakleaf Care Group - Referral Form

www.oakleafcare.com

Client Details

Surname:		Forenames:	
Date of Birth:		Ethnicity:	
Legal Status (informal/detained)		Marital Status:	
Name & Address of Spouse/Partner			
Next of Kin Address & Tel:			

Referrer Details

Name:			
Designation:			
Organisation:			
Address:			
Postcode:			
Telephone:		Fax:	
Email:			

Current Placement Details	
Organisation:	
Address:	
Postcode:	
Telephone:	Fax:
Email:	

GP Details	
Name:	
Practice Name:	
Address:	Postcode:
Telephone:	Fax:
Email:	

Who is the Client's DOL Supervisory Body?
(name, address & contact number)

Client History	
Date of Brain Injury:	
Details of Injury: (including duration of unconsciousness and any other injuries)	
Medical History (including pre-existing conditions and mental health)	
Forensic History / Community Orders / Restrictions	
Social History (please give details of schooling, work history and relationships)	
Current Medication	

Living Skills

Continence	YES / NO	Please give details including staff required
Independent?		
Urinary incontinence		
Faecal incontinence		
Eating and Drinking	YES / NO	Please give details including staff required
Fully independent?		
Requires assistance (e.g. aids, 1:1 staff)		
Any other needs (e.g. dietary, PEG, dysphagic)		
Personal Care	YES / NO	Please give details including staff required
Fully independent?		
Requires assistance?		
Mobility	YES / NO	Please give details including staff required
Fully independent?		
Requires assistance? (including wheelchair, hoist or any other equipment and numbers of staff required to assist)		

Sensory Skills	Please give as much information possible
Hearing	
Vision	
Communication	

Levels of aggression/ frequency	Daily	Weekly	Monthly (specify if over)
Verbal aggression			
Physical aggression against objects			
Physical aggression against self			
Physical aggression against others			

Risk Behaviours	Please describe
Wandering / absconsion	
Intimidation / bullying	
Arson	
Suicide / self harm	
Vulnerability	
Sexual Disinhibition	
Alcohol / substance misuse	

Memory / Cognitive Abilities

Mental Capacity – Has this been assessed?

Resident expectations/wishes if admitted to Oakleaf Care?

Any other relevant information

(please include any other relevant areas of difficulty and details of family involvement in current care/contact)

Additional Contact Information	Name	Telephone Number
Consultant / RMO		
Care Co-ordinator/Named Nurse		
Advocate		
Social Worker		
Solicitor		

Responsible Purchaser Contact Details	
Name:	
Designation:	
Address:	
Telephone Number:	
Is the purchaser aware of this referral?	

How did you hear about Oakleaf Care?

Referral form completed by:

Name _____ Designation _____

Address _____

_____ Post Code _____

Telephone number _____ Date completed _____