

**Arrangement of Care and Support Service**

 **Referral Form**

Please complete this form if you identify an individual who is eligible for a service from the Local Authority or Integrated Care Board (ICB), or who would like further information/support. It is important that you complete the form with as much information as possible for us to be able to provide them with the appropriate support and guidance.

**Please note referrals will be rejected unless the form is completed with all relevant information.**

|  |  |
| --- | --- |
| Referral date: |   |
| Broad Care ID: (if applicable) |   | Liquid Logic ID(if applicable) |   |
| **Client Details** | **Contact details (if different to client)** |
| Name: |  | Name: |  |
| Address:Postcode: |  | Address(if different): |  |
| Tel No |   | Tel No |  |
| Email: |   | Email: |  |
| Date of Birth: |   | Relationship: |  |
| **Referrer Details:**A named Social Worker or ICN is preferable please note that if the referral is from the Duty Team then all correspondence will be sent to the Duty Team until advised otherwise. | Name: Position: Organisation: Tel: Email:  |
| Reason for referral | Hospital Discharge  | [ ]  | Ongoing advice | [ ]  | Support Plan | [ ]  |
| DP referral | [ ]  | Self funder | [ ]  |
| A description of assessed need and the support required. **This is important as we need to make sure that the assessed need is being met**.  |   |
| **What outcomes are to be achieved?** |   |
| **Is reablement/rapid in place** | Yes | [ ]  | No | [ ]  |
| Assessments included for use in support planning:**Insert any of the documents from the list here.** | Decision Support Tool **essential for PHB’s** | [ ]  | Care Plan | [ ]  |
| Community Care Assessment **for Adults** | [ ]  | Provider Report | [ ]  |
| Nursing Needs Profile | [ ]  | Care Needs Assessment **Essential for those awaiting hospital discharge** | [ ]  |
| Funding source (please include % split if joint funded) | CCG | [ ]  | Self Funder | [ ]  | Social Care | [ ]  |
| Indicative Budget **The referral will be refused without this.** | (not required if self funder)  |
| Client Financial Contribution (If applicable) **We need this to ensure that the payments are made.** | £  |
| Does the person have capacity to make decisions about their care? If No then please state who will be their representative and their relationship to client? |

|  |  |  |  |
| --- | --- | --- | --- |
| Yes | [ ]  | No | [ ]  |

Name: Address: Tel: Relationship to client:  |
| Does the person require an Aerosol Generated Procedure? |

|  |  |  |  |
| --- | --- | --- | --- |
|  Yes | [ ]  | No | [ ]  |

If yes please provide details: |
| Is a joint visit required? |

|  |  |  |  |
| --- | --- | --- | --- |
|  Yes | [ ]  | No | [ ]  |

 |
| Any risk factors in home: (e.g. pets, accessibility, smoker etc) | no |
| Communication:(e.g. interpreter required, pictorial)  |    |
| Consent**The referral will be refused without this.** | I have read and understood how you will use and process my data for this service and I have informed any relevant third-parties of the information I provide to you about them, in line with the [privacy notice](https://disabilitypositive.org/privacy-policy/)**Please tick to confirm** [ ]  |

**Please return completed forms to:** **triage@disabilitypositive.org**

**Tel: 03333 660107**

|  |  |
| --- | --- |
| A close up of a sign  Description automatically generated**Arrangement of Care and Support Client****Consent Form** |  |

The Arrangement of Care and Support Service promotes choice, control and independence. We work with you and your family to assist with the planning and arrangements of your care or support package. Anything that is arranged can be adapted later in response to your needs and wishes.

**Third Party Authorisation:**

**Please tick one of the boxes below:**

[ ]  I wish to deal directly with the Arrangement of Care and Support Service provider(s)

or

[ ]  I would like to appoint a authorised representative (whose details are below) to liaise with the Arrangement of Care and Support Service provider(s) regarding the organisation of my care package.

|  |  |
| --- | --- |
| My name: |   |
| Date: |   |
| Representatives Details:  | Name: Address: Email: Tel: Relationship to you:  |

**Consent**

In order to help you, we need to store information about you. As some of this information is deemed sensitive (e. g. information about your health) under the Data Protection Act 1998 and the General Data Protection Regulations 2018, we require your consent to process this information.

I have read and understood how you will use and process my data for this service and I have informed any relevant third-parties of the information I provide to you about them, in line with the [privacy notice](https://disabilitypositive.org/privacy-policy/)

Signed Date

**Please return completed forms to:** **triage@disabilitypositive.org**

**Early Tel: 03333 660107**