**Health Wellbeing and Care Hub**

**Adult Services Referral Form**

Please give as much information as possible. This will help us to process your referral quickly and appropriately. If you require support to complete the form, please contact us on 01206 872460 or email [healthwellbeingcare@essex.ac.uk](mailto:healthwellbeingcare@essex.ac.uk). Please attach any additional information on a separate sheet.

Your care will be provided by our student workforce under the supervision of HCPC registered practitioners. Please tick the box to give consent to be seen by our students

Services available: please tick the service/s you are referring to:

**Move and Meet**

**Upper Limb Rehab**

**Working Age Exercise Group**

**Reminiscence Cafe**

**1:1 Neuro Rehab Service**

**Living with Neurological Conditions**

**1:1 Physiotherapy**

**1:1 Occupational Therapy**

**Swallow Clinic**

**Neuro-rehabilitation Online Clinic**

**Augmented Reality Parkinson’s Group**

**Moving for Independence**

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| **Personal Details** | | | |
| Title: | First Name: | | Surname: |
| Preferred Name: | | Date Of Birth: | |
| Address:  Postcode: | | | |
| Telephone number: | | | |
| Email: | | | |
| First language:  *If English is not your first language, please bring someone with you to support your communication.* | | Ethnicity: | |
| Religion: | |
| Gender: | |
| Next of Kin  Name:  Telephone Number:  Relationship: | | GP Name:  GP Address:  Telephone Number: | |
| Preferred contact method: | Phone  Email  Letter | | |

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| **Medical History** | |
| Current and past medical history.  *Please include dates of major surgeries, events and diagnoses where possible*  *\*Please bring copies of any discharge letters and reports with you to your first appointment*  \*Please bring a list of medications with you to your first appointment (these are available on the NHS app if you don’t have a copy of your prescription.) | Epilepsy Yes  No  Epilepsy Management Plan in place: Yes  No  *If YES, please give details:*  Blood Pressure Issues Yes  No  If YES, please give details:  Diabetes Yes  No  Type 1  Type 2  Other |
| Mobility and accessibility. | Please detail any support you require with regards to accessibility and mobility.  E.g. walking aids, wheelchair user.  Do you require accessible parking? Yes  No  *If yes, please ensure you have your blue badge with you.*  Are you able to access the Hub in person? Yes  No  *If you need support to travel to the HWCH, please ask us for advice on how to access your local community transport service scheme.* |
| Hearing difficulties: | Yes  No  *If yes, please advise if you would like access to the hearing loop.* |
| Visual difficulties: | Yes  No  *If yes, please specify.* |
| Previous/Ongoing input from healthcare professionals: | *Please include dates and details of treatment where possible including physiotherapy, occupational therapy, speech and language therapy, psychology etc and what the outcome was. Please note when you were discharged from these services if this is the case.* |

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| **Reason for Referral** | |
| Reason for referral:  What are your current concerns and difficulties? | *Please provide as much detail as possible.* |
| What would you like to achieve by attending the service? | *Please give as much detail as possible.* |

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| *Please use this section if you would like to add any additional information, thank you.* |

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| **Referrer Details** | | | |
| Referrer Details:  (if not self-referral)  Name and organisation |  | Date of referral: | Click or tap to enter a date. |
| Referrer’s Address: |  | Email: |  |
| Telephone Number: |  | Consent obtained to send: | Yes  No |

**Please email the completed form to: healthwellbeingcare@essex.ac.uk**

**Office use only:**

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| Comments: |