**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:

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| **Move and Meet** | **1:1 Adult Physiotherapy** |
| **Upper Limb Rehab** | **1:1 Adult Occupational Therapy** |
| **1:1 Neuro Rehab Service** | **Neuro-rehabilitation Online Clinic** |
| **Prehabilitation** | **Augmented Reality Parkinson’s Group** |

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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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| **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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| **Current Medical History** | | |
| **Current Medical Condition/s** | *Please tell us about your current health status, including any diagnoses, such as high blood pressure, epilepsy, diabetes etc.* | |
| **Current Medication/s** | *Please list the name and dose of any regular medications that you are prescribed.* | |
| **Past Medical History** | | |
| **Please bring copies of any discharge letters and reports with you to your first appointment or share with us, as part of this referral.** | *Please include dates of major surgeries, events and diagnoses* | |
| **Mobility and accessibility** | *Please specify if you use a walking aid, wheelchair user or are independently able to walk.*  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 | |
| **Hearing difficulties:** | Yes  No  *If yes, please advise if you require access to our hearing loop.* | |
| **Visual difficulties:** | Yes  No  *If yes, please specify.* | |
| **Previous / Ongoing input from healthcare professionals:** | *For example: physiotherapy, occupational therapy, speech and language therapy, psychology etc.* | |

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

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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 refer:** | Yes  No |

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

*If you need support to travel to the HWCH, please ask us for advice on how to access your local community transport service scheme.*

**Office use only:**

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| Comments: |