

Medicines Support Team Referral Form

**Request for Medicines Review, Home Assessment, Medicines Advice and Review of Support Needs**

We aim to arrange appointments within 10 working days of receipt. Please contact the service if you need to discuss further.

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| **Name of patient** | **NHS Number** |
| **Address** | **Date of birth** |
| **Telephone** |
| **Postcode** |
| **GP practice** | **GP telephone no.** |
| **Consent- We are unable to accept referrals without the patient consent.**□ Patient has consented to referral, viewing shared records, and sharing information.□ Referral made in best interest (Mental Capacity Act 2005)  |
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| **Safeguarding**Can staff visit alone? □ Yes □ NoIf NO, provide details of known risks to self or others: |
| **Referral Criteria**□ Dexterity Problems □ Difficulty remembering or managing medication □ Falls risk □ Recent Hospital Discharge □ Recent changes to Medication □ Swallowing difficulties □ Education about medicines □ Complex medication regimens □ Adverse drug reaction□ Other……………………………………………………………………………………………………………………………………………………………………………**Reason for Referral** Please give clear details to support triage. (Continue on page 2 if necessary). |
|  **Who should the visit be arranged with?**  □ Patient □ Representative Name Relationship Tel Mobile  **Who is responsible for medicines?** □ Self-administers □ Family Support □ POC □ Other**Does the patient have any communication needs:**□ Language difficulties – Language Spoken…………………………………………… □ Hearing Difficulties □ Visual Impairment□ Communication issues – (please state)……………………………………………………………………………………………………………. |
| **Name of referrer** | **Date** |
| **Occupation / Department** | **Contact details** |

# Email completed form to

# 🖂 medicinessupportteam@elht.nhs.uk 🖂 medicinessupport.elht@nhs.net

✆**Telephone 01282 803170**

**Additional Information / Continuation Sheet**

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# 🖂 medicinessupportteam@elht.nhs.uk or 🖂 medicinessupport.elht@nhs.net

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