Medicines Support Team Referral Form

East Lancashire Hospitals NHS Trust

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.

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 patients consent.

- ☐ 1. The patient has consented to this referral
- ☐ 2. The patient has consented to the viewing of shared records for the purpose of the referral
- ☐ 3. The patient has consented to the sharing of information with other professionals involved in their care
- ☐ 4. This referral is a 'best interest' decision made on behalf of the patient (MCA 2005).
- ☐ 5. The patient is deemed not to have capacity

Reason or referral – please provide information to support triage of this referral. Continue on page 2 if necessary.

The Patient

☐ Lives alone ☐ Is housebound ☐ Is at risk of falls ☐ Takes four or more regular medicines

Has difficulty in managing or remembering to take their medicines – please tick all that apply

☐ Dexterity problems ☐ Impaired sight ☐ Dementia / memory ☐ Confusion
☐ Learning disability ☐ Swallowing difficulties Other – please state

- ☐ Is at risk of admission / readmission to hospital Please Select:
- ☐ Has recently been discharged from hospital - date _____
- ☐ Has a Reablement package in place - date commenced _____
- ☐ Has had recent changes to their medicines which may need explaining
- ☐ Would benefit from further education on the use of their medicines
- ☐ Has symptoms of an adverse drug reaction/side effects, or the medicine is not effective Please Select:

Services active in this patients care (Please indicate(x) other services involved)

IDS / ICAT / IHSS / Social Services / INT / Therapies / Other _____

Does the patient require support / representation at the assessment?

With whom should the visit be arranged? Please provide daytime contact numbers

Name _____Relationship _____Tel _____ Mobile _____

Who is responsible for medicines?

Name _____Relationship _____Tel _____ Mobile _____

Next of kin

Name _____Relationship _____Tel _____ Mobile _____

Does the patient have any communication needs:

☐ Language difficulties ☐ Interpreter needed ☐ Language Spoken _____
☐ Literacy difficulties ☐ Hearing difficulties ☐ Independent Advocate needed

Safeguarding

Please provide details of any known risks to self or others?

Is it safe for staff to visit alone?

Name of referrer	**Date of referral**
Occupation / Department	**Contact details**

Complete and submit online at ELHT.nhs.uk/Services/MedicinesSupport

Email to medicinessupportteam@elht.nhs.uk , medicinessupport.elht@nhs.net or return by post to Medicines Support Team, Burnley General Hospital, Casterton Avenue, Burnley, BB10 2PQ Telephone 01282 803338

Additional Information / Continuation Sheet

Print Save Email

Complete and submit online at ELHT.nhs.uk/Services/MedicinesSupport

Email to medicinessupportteam@elht.nhs.uk , medicinessupport.elht@nhs.net or return by post to Medicines Support Team, Burnley General Hospital, Casterton Avenue, Burnley, BB10 2PQ Telephone 01282 803338