**Adult Services: Referral Form**

**Please use this form if you are referring someone to Social Services.**

Please do not use this form for urgent or emergency enquiries. Please contact the Common Access Point on 01792 636519 in this instance. Our opening hours are: 8.30am - 5.00pm Monday to Thursday and 8.30am - 4.30pm Friday. If there is an emergency outside these office hours please contact the Emergency Duty Team on 01792 775501.

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| **Please tell us about yourself** |
| **Are you:**  Making a referral on behalf of a friend or a family member?  A member of hospital staff referring a patient?  A health, social care or other professional referring a patient or client?  Other?  **Please note:**  If you wish to refer someone you know, you must have their consent to do so.  Have you sought and gained consent? Please check if Yes  If no, please state why: |
| What is your relationship to the person you are referring?  Choose an item. |
| Your Title:  Choose an item. |
| Your Name: |
| Occupation if applicable: |
| House Number or Name / Number of Surgery, Hospital or Organisation: |
| Street Name: |
| Area: |
| Postcode: |
| Telephone Number: |
| Email Address: |
| Are there any risks or safety issues associated in working with this person? Consider pets, access, sensitivities etc. |
| Is the person being referred comfortable communicating through English?  Choose an item. |
| If no, please state preferred language: |
| **Patient details: Please only complete if person being referred is in hospital** |
| Patient ID: |
| Ward/ Department: |
| Date of hospital admission:  Click or tap to enter a date. |
| Reason for admission: |
| Estimated discharge date:  Click or tap to enter a date. |

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| **Please tell us about the person you are referring** |
| Title  Choose an item. |
| First name: |
| Surname: |
| Date of birth:  Click or tap to enter a date.  If date of birth unknown state approximate age: |
| Ethnic origin:  Choose an item. |
| House Name / Number: |
| Street Name: |
| Area: |
| Postcode: |
| Telephone: |
| Email: |
| **Details of Doctors surgery** |
| If you have not already given Surgery details above, please do so here: |
| Name of Doctors surgery: |
| Street Number: |
| Street Name: |
| Area: |
| Postcode: |
| Telephone: |
| **Further details** |
| Are there any other health or social services professionals already supporting the person you are referring?  Choose an item. |
| If yes, please give details: |
| Is the person being referred subject to a Care Programme Approach?  Choose an item. |
| If yes, who is the Care Co-ordinator? |
| **Next of Kin** |
| Name: |
| Relationship to person being referred: |
| House Name / Number: |
| Street Name: |
| Area: |
| Postcode: |
| Telephone: |
| **Communication and working together** |
| Does the person you are referring have any visual impairments? |
| Does the person you are referring have any hearing impairments? |
| Does the person you are referring have any other disabilities? |
| **Reason for referral** |
| Describe briefly what has made you contact us?  Consider what difficulties are being experienced?  What help is needed?  Any significant health condition or disability.  Are there indications of abuse or neglect? How urgently is help needed?  Any other information that you feel may be useful. |

**How will Swansea Council manage your personal information?**

Swansea Council is the data controller for the personal information you provide on this form. Your information will be used in the exercise of our official authority and will not be used for any other purpose. We will not share your data with third parties unless we are required or permitted to do so by law.   
  
Data protection law describes the legal basis for our processing your data as necessary for the performance of a public task. For further information about how Swansea Council uses your personal data, including your rights as a data subject, please see our corporate [privacy notice](https://www.swansea.gov.uk/privacynotice) on our website.

**Please return completed form to CAP@Swansea.gov.uk**