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**Older Adults Mental Health Team Referral Form**

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|  **Full Name**  |  | **Ethnicity** |  |
| **D.O.B/Age****NHS Number** |  |
| **Phone Number** |  |
| **Address** |  | **Mobile Number** |  |
| **Client email address** |  |
| **GP Surgery** |  | **Mental Health Diagnosis** **Physical Health Diagnosis**  |
| **Date of referral** |  |
| **Reason for referral / support needs**  |  |
| **Ex-Military Services****Y / N** | **Is the client a carer?****Y / N** | **Does the client live alone?****Y / N** | **Is there a care package in place?****Y / N** |
| **Issues to note when visiting eg: any known risk to others , pets, mobility, access, safeguarding** | **In receipt of any benefits****Y/N/Unknown** | **Are there any memory issues****Y/N/Unknown** |
| **Referred By:** | **Self** | **Relative** |  | **Professional Contact** | **Other** |
| **Details of Referrer****(Name and organisation)** |  | **Contact Number** |  |
| **Email address** |  |
| **Support Provided** | **Information Provided** |  |  |
| **Signposted on to** |  |
| **Home Visit Booked** |  |
| **Phone call required** |  |
| **Data Protection – Consent to Share**We will store and process this information in accordance with the requirements of their Data Protection Policies and in keeping with the Data Protection Act 1998.**I am happy for Age UK Oxfordshire/Connection Support to store and process my details and to share with partner agencies if appropriate:****Name:****Date:****Signature:**Verbal consent given to sharing of details with Oxford Health (please delete) YES / NO |

Please forward your completed referral form via email to OAMH@connectionsupport.org.uk