

# COMMUNITY OCCUPATIONAL THERAPY REFERRAL

PLEASE COMPLETE **FULLY** IN ORDER TO PROCESS YOUR REFERRAL

**Locality:**

☐ Downpatrick

☐ Lisburn

☐ North Down and Ards

**Email completed forms to or see postal address at the end:**

[downpatrick.communityot@setrust.hscni.net](mailto:downpatrick.communityot@setrust.hscni.net)

[lisburn.communityot@setrust.hscni.net](mailto:lisburn.communityot@setrust.hscni.net)

[community.ot@setrust.hscni.net](mailto:community.ot@setrust.hscni.net)

<b><u>Surname:</u></b>	<b><u>Forename:</u></b>	<b><u>Mr / Mrs / Miss / Ms</u></b>
<b><u>Address:</u></b>		
<b><u>Post Code:</u></b>	<b><u>Tel No:</u></b>	<b><u>Mobile:</u></b>
Previous Address:		
<b><u>Date of birth:</u></b>	<b><u>H&amp;C No (if known):</u></b>	
<b><u>GP Name:</u></b>		
<b><u>Address:</u></b>		
Are there any other Professionals involved? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		
Care Manager involved? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		

<b><u>Primary Diagnosis:</u></b>
<b><u>Relevant Medical History (including psychiatric history)</u></b>

<b><u>Please identify the problems experienced and reason for referral:</u></b>
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**HOME SITUATION: (PLEASE TICK)**

- ☐ Lives alone
- ☐ Lives with other elderly person(s)
- ☐ Lives with other disabled person(s)
- ☐ Lives with able-bodied family members

Name of Main Carer:

Tel:

Next of Kin:

Tel:

**Ownership:**

- ☐ NIHE                      ☐ Housing Association                      ☐ Privately owned                      ☐ Privately Rented

**House Type:**

- ☐ Flat Ground Flat                      ☐ Bungalow
- ☐ Flat 1<sup>st</sup> Floor                      ☐ Two Storey
- ☐ Flat Other Floor

Bedroom    ↓ ☐ ☐ ↑ ☐

Bathroom   ↓ ☐ ☐ ↑ ☐

Toilet        ↓ ☐ ☐ ↑ ☐

**Is there anything we need to know before we visit your property?**

Yes ☐ specify \_\_\_\_\_

No ☐

***CAN CLIENT ATTEND ASSESSMENT CLINIC?***    Yes: ☐                      No: ☐ \*

*\* If no please state reason.* \_\_\_\_\_

**Referred by:** \_\_\_\_\_ **(Relationship (if appropriate):** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Tel. No.:** \_\_\_\_\_

**If you are making a referral on behalf of someone does the Client consent to referral?**

Yes ☐ No ☐ **Date:** \_\_\_\_\_

**Return completed forms to the relevant office below:**

**DOWNPATRICK:** Community Occupational Therapy Department, Disability Resource Centre, Downshire Hospital, Downpatrick, BT306RA or by email to [downpatrick.communityot@setrust.hscni.net](mailto:downpatrick.communityot@setrust.hscni.net)

**LISBURN:** Community Occupational Therapy Department, Lisburn Health Centre, Linenhall Street, Lisburn BT28 1LU or by email to [lisburn.communityot@setrust.hscni.net](mailto:lisburn.communityot@setrust.hscni.net)

**NORTH DOWN & ARDS:** Community Occupational Therapy Department, Administrative Offices, Newtownards Road, Bangor, BT20 4LB or by email to [community.ot@setrust.hscni.net](mailto:community.ot@setrust.hscni.net)