Ballinasloe Social Services Day Centre Referral
Brackernagh,
Ballinasloe
Phone: 090 9643217 **Fax**: 090 9645197

Client Name:	GP**:**	Location:
Lives alone: Yes ☐ No ☐		Phone No:
Address (Please include PostCode)	P.H.N	Phone No:
Telephone No:	D.O.B	
Next of Kin & Relationship to Client:	Main Carer & Relationship to Client:	
Phone No. of next of Kin:	Phone No. of main carer:	

Relevant Medical History (Please include Doctor's Letter). _____

_____

_____

_____

Current Medication _____

_____

Any known allergies (Medication/ Foods):_____

Diabetic Yes ☐ No ☐ Warfarin Therapy Yes ☐ No ☐

History of falls _____

Does the client wander? Yes ☐ No ☐

Give details _____

Reason For Referral

_____

_____

Will client use own private transport? ☐ Bus transport required if covering that area? ☐

Currently receiving Meals on Wheels? ☐

Directions to House (if required) _____

_____

General Condition		Mental State		Mobility		Continence		Transfer/Chair/Toilet
Good	☐	Alert	☐	Independent	☐	Full continence	☐	Independent
Fair	☐	Confused	☐	Slightly limited	☐	Urinary Incontinence	☐	Assist x 1 ☐
Poor	☐	Behaviour that challenges	☐	Immobile	☐	Double Incontinence	☐	Assist x 2 ☐
				Aids		All Products to be supplied by Client to Day Centre		
				Zimmer frame	☐	If Wheelchair Transportation on bus required, is Wheelchair crash-tested? Yes /No		
				Wheelchair	☐			
				Stick	☐			
Explain:		Details						

Reviewed by: O.T. Yes ☐ No ☐ Date: _____

Reviewed by: P.T. Yes ☐ No ☐ Date: _____

Reviewed by S.A.L.T	**Yes ☐ No ☐ Date: _____**
DIET	
Normal	Special
Swallowing difficulties	Consistency Fluids: Foods:

Referred By:_____ Contact No: _____ Grade: _____ Date:_____

Office Use Only:

Referral Received By_____ Date:_____

Multidisciplinary Discussion_____ Date: _____

Outcome: Bus Availability _____ Trial Day: _____