BALLINASLOE SOCIAL SERVICES

Brackernagh, Ballinasloe

Day Centre Referral Form

Phone: 090 9643217 Email:mandy@ballinasloesocialservices.ie

Client Name:	**D.O.B.**
Address:	
Eircode:	**Telephone No:**
Lives Alone: Yes ☐ No ☐	
Next of Kin:	**Contact No. of Next of Kin:**
Main Carer:	**Contact No. of Main Carer:**
GP:	**GP Contact No:**
Public Health Nurse:	**PHN Contact No:**
Relevant Medical History: _____ _____ _____	
Diabetic: Yes ☐ No ☐ **If Yes: Non-Insulin Dependent** ☐ **Insulin Dependent** ☐	**Any allergies (Medication/Foods):** Yes ☐ No ☐ **Details of Allergies:**
Current Medications: _____ _____	
Anti-Coagulant Therapy: **Yes** ☐ No ☐ **(Blood thinning medications)**	

Reason for Referral: _____

_____

_____

Will client use own transport? ☐ **Bus transport require if covering that area?** ☐

Currently receiving Meals on Wheels? Yes ☐ No ☐

PLEASE SELECT ONE			
GENERAL CONDITION	GOOD ☐	FAIR ☐	POOR ☐
MENTAL STATUS	ALERT ☐	CONFUSED ☐	DETAILS
MOBILITY	INDEPENDENT ☐	ASSISTED ☐	IMMOBILE ☐
MOBILIITY AIDS	WALKING STICK ☐	ZIMMER FRAME ☐	WHEELCHAIR ☐
HYGIENE NEEDS	INDEPENDENT ☐	ASSIST X 1 ☐	ASSIST X 2 ☐
CONTINENCE	FULL CONTINENCE ☐	URINARY INCONTINENCE ☐	DOUBLE INCONTINENCE ☐

REVIEWED BY OT	YES ☐ NO ☐	DATE:
REVIEWED BY PHYSIO	YES ☐ NO ☐	DATE:
REVIEWED BY S.L.T	YES ☐ NO ☐	DATE

SWALLOWING DIFFICULTIES	YES ☐ NO ☐	
DIET	NORMAL	SPECIAL
CONSISTENCY	FLUID:	FOODS

Referred by: _____ **Grade:** _____ **Date:** _____

Office Use Only:

Referral Received By: _____ Date: _____

Referral Reviewed: _____ Date: _____

Availing of Transport: _____ Trial Day: _____

Notes: _____

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