|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Office use only:** | |  | **FCP:** | | **REF:** | |
| **Please complete fully and send directly to Focused Care Practitioner:** | | | | | | |
| * Focused Care is suitable for patients who present with multiple issues that cross health and social boundaries often described as Failure to Thrive (see attached sheet for full criteria) * Please note that Focused Care is not an emergency service. * If your patient is in acute mental health crisis you will need to also refer them to the crisis or RAID team. * If your patient needs an urgent referral to safeguarding please do this directly, and do not delay this referral. | | | | | | |
| **PLEASE ENSURE PATIENT IS AWARE OF REFERRAL AND HAS GIVEN VERBAL CONSENT TO BE CONTACTED BY AND THEIR DETAILS SHARED WITH FOCUSED CARE.**  **FOCUSED CARE WILL GAIN FULL CONSENT ON INITIAL ASSESSMENT** | | | | | | |
| **Patient details:** | | | | | | |
| Full Name |  | | | | DOB: |  |
| Address |  | | | | Postcode: |  |
| NHS No. |  | | | | EMIS No. |  |
| Preferred Pt Contact number |  | | | | | |
| Language support required? (If Yes please provide details)  Main spoken language: | | | | | | |
| Patient Medical Summary attached / Refer to EMIS | | | | | | |
| **Risk Assessment for lone working staff safety:**  Does this patient have a history of violence? Yes / No (If yes please attach details)  Is this patient unpredictable or abusive to staff? Yes / No (If yes please attach details)  Is this patient known or suspected to be involved in serious crime? Yes / No (If yes please attach details)  Do you have any other concerns we need to know ahead of visiting this patient?  Yes / No (If yes please attach details) | | | | | | |
| **Reason(s) for referral:** | | | | | | |
| **Initial desired outcome of Focused Care Plan:** | | | | | | |
| **Any further comments and/or other known agencies involved?** | | | | | | |
| **Referring surgery details:** | | | | | | |
| Surgery Name: | | | | Primary Care Network: | | |
| Surgery contact number: | | | | | | |
| Surgery contact email: | | | | | | |
| Name of referrer: | | | | Referrer contact: | | |
| Surgery Link GP/Clinician: | | | | Date of referral: | | |

Please continue onto another sheet if required. End

**Referral Criteria for Focused Care**

(prevention, promotion of independence, minimisation of risk)

1. Patients who do not respond well to present care plan
2. Patients who abuse themselves or are abused by others (substance/sexual risk-takers etc)
3. Families who are already identified as having Child in Need or Child protection Care Plans i.e. do not provide “good enough” parenting
4. Patients who have complex holistic health issues in their lives which impact their health, safety and independence
5. Those who are excluded from society for various reasons
6. Where neglect or self-neglect is evident
7. Where other professionals or the community have serious concerns
8. Non-compliance with or inappropriate accessing of services

The patient/family will go on/off the Focused Care referrals if

…. 1) is ticked …. 2 or more other criteria can be ticked