

**Manchester Case Management South Locality**

***( Previously known as High Impact Primary Care & Active Case Managers*)**

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **PATIENT DETAILS** | | | | | | | | | | | |
| **Name** |  | | **Emergency Contact (family member, friend, neighbour, carer/s)** | | | | | | | | |
| **Address** |  | | **Name** | | | |  | | | | |
| **Home Telephone** |  | | **Relationship** | | | |  | | | | |
| **Mobile Telephone** |  | | **Contact Telephone** | | | |  | | | | |
| **Age** |  | | **Main Language** | | | |  | | | | |
| **Date of Birth** |  | | **Interpreter required?** | | | | **Yes** | | | **No** | |
| **NHS Number** |  | | **Other communication needs? (Please state)** | | | | | | | | |
| **GP DETAILS** | | |
| **Name** |  | |
| **Address** |  | |
| **Telephone** |  | |
| **REFERRER DETAILS** | | | | | | | | | | | |
| **Name** |  | | | **Contact Number** | |  | | | | |
| **Date of referral** |  | | |
| **Does the patient know they are being referred?** | | | | | **Yes** | | | | **No** | | |
| **Does the patient live alone?** | | | | | **Yes** | | | | **No** | | |
| **Are there any safety issues?** | | | | | **Yes** | | | | **No** | | |
| **Is the patient housebound?** | | | | | **Yes** | | | | **No** | | |
| **Key Code** | | | | |  | | | | | | |
| **REASONS FOR REFERRAL:**  **Please give as much information as possible explaining the patient’s needs. This will enable us to triage the referral. Please include relevant information / reports.** | | | | | | | | | | | |
| **Medical History / Chronic Conditions / Allergies** | | | | | | | | | | | |
| **Social history / Risk Factors** | | | | | | | | | | | |
| **Please complete all sections of the form. Any incomplete referrals may be returned to the referrer. Please send via Emis referral / email to mft.spa-uhsm@nhs.net** | | | | | | | | | | | |
| **Exclusion Criteria** | | | | | | | | | | | |
| **Under 18** | | **In a nursing home** | | **End of life** | | | | **Mental Health Crisis** | | | |