

**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** |