**Westminster Severe Multiple Disadvantage Health Referral**

\*Please include as much information as possible and email this form to [clcht.homeless@nhs.net](mailto:clcht.homeless@nhs.net)

Contact the nurses if you are unsure whether the referral meets inclusion criteria.

Moya Forsythe: 07769 913 835 Sharon Stephens: 07443 299 885

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| --- | --- | --- | --- |
| Client | | | |
| Family name |  | First name |  |
| Date of birth |  | Gender |  |
| NHS No |  | Ethnicity |  |
| Preferred language: |  | Interpreter | Yes  No |
| Accomodation / sleep and day time site(s) |  | | |
| Tel (if available) |  | CHAIN ID |  |

|  |  |  |
| --- | --- | --- |
| **Team around the person** | | |
| General Practitioner | Great Chapel Street  The Doctor Hickey Surgery  Other | |
| **Support service** | **Key worker email** | |
| St Mungos  Compass  SET  SHP floating support |  | |
| Turning Point  CGL  Blue Light Project |  | |
| Psychologist |  | |
| Probation worker |  | |
| Day centres |  | |
|  |  | |
|  |  | |
| **Presented at the Enhanced Vulnerability (EVF) or equivalent forum** | | No  Yes  Date: |

|  |  |
| --- | --- |
| **Safeguarding and / or Westminster alerts** | |
| Alerts |  |
| Safeguarding referral |  |
| No lone working identified | No  Yes |
| Does the person have any behavioural issues, whether these are as a result of a disability, a mental health condition, sensory processing disorder, or for any other reason? No  Yes | |

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| **Reason for referral** |
| **Inclusion criteria**   * People experiencing SMD, and unmet physical health needs that puts them at high risk of avoidable harm\*; who do not use primary care services, and frequently call an ambulance or attend A&E because they are unable to engage with existing specialist services (\*excludes chronic disease management) * Westminster borough including on the border * People with a Westminster connection housed outside of Westminster to be considered on a case-by-case basis |
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| **CONSENT** | |
| Client consent for referral | Yes  No |

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| Referrer | | | | | |
| Name | Completed via T/C with duty | Designation |  | | |
| Team /Organisation |  | | | | |
| Address |  | | | Tel |  |
| Email |  | | | Date |  |

|  |  |
| --- | --- |
| **Office use: referral outcome** | |
|  | |
| Accepted: | Name: |
| Advised and signposted : | Date: |