Integrated Care Services for Older People Referral Form
Incorporating:

- *Rapid Assessment Clinics for Memory, Complex unexplained falls, Frailty*
- *Ambulatory Outreach Service*

Name: **Male:** ☐ **Female**: ☐ D.O.B **:** **Phone Number(s):** **Contact Person**: **Contact Details:** **Patient MRN:**	**Address:** **GP Name and Contact details:** **Does the client give consent for sharing of information between primary care members on a need to know basis:** YES ☐ NO ☐ ____________________ **Are there any safety issues staff needs to be aware of for home visits?** YES ☐ NO ☐ ____________________

Health Care Services Involved in the community:

PHN ☐ Name/Health Centre : ____________________

O.T ☐ Physio ☐ Day Care ☐ Mental health ☐ Dietetics ☐ Speech and language ☐ Social Worker ☐

Other (Specify e.g previous reviews by GEMS/ Rapid Access) : ____________________

Level of Support:

Lives: Alone ☐ With Family ☐ Home Help ☐ Meals on Wheels ☐

Other (Please Specify): ____________________

Reason for Referral and Intervention

Previous Relevant Medical History: ie; Surgical/Psychiatric history, treatment received & current diagnosis (In addition, please provide discharge summary at time of discharge):

Falls History:

YES ☐ NO ☐ If yes, please provide details:

- 2 or more falls in the last 6 months yes/no
- Needing further medical investigations(e.g dizziness,vertigo) yes/no
- Complex medication issues yes/no

Is English this patient's first language? YES ☐ NO ☐ If not, which language is? ____________________	**Known allergies, alcohol or drug addiction?**
Full Prescription supplied? & discharge letter? (please attach) YES ☐ NO ☐ YES ☐ NO ☐	**Infection Control Status**; MRSA, C-Diff, VRE, COVID-19, Other?
Mobility Status Independent ☐ Use of aids __________________ Level of assistance required ______________________________________	**Cognitive Status** Orientated ☐ Confused ☐ 4AT Score ☐ MMSE ☐ MOCA ☐
Communication deficits YES ☐ NO ☐ If yes please give details :	**Other Concerns or information you consider relevant (please specify):**

Has the patient been reviewed by		Additional Information attached
FITT	**YES/NO**	**YES/NO**
GP	**YES/NO**	**YES/NO**
Geriatrician/Name	**YES/NO**	**YES/NO**
ANP	**YES/NO**	**YES/NO**

Please identify which service you wish to access

RAPID ASSESSMENT SERVICE • Cork South Hub SFH • Cork North Hub St.Mary's Health Campus covering Community Networks 7,8,9.	**CONTACT** corksouth.icpop@hse.ie CorkNorthCity.icpop@hse.ie
Multi-factorial assessment to prevent/avoid hospital attendance or admission *Specialist Older Person Multi-Disciplinary Team including assessment by Nursing, Physiotherapy, and Occupational Therapy.*	☐
AMBULATORY OUTREACH TEAM	**CONTACT** corksouth.icpop@hse.ie **0871800953**
• Have acute care needs that can safely be managed at home • Requires Specialist Multidisciplinary Rehabilitation at home	☐ ☐

Referrers Name:	Telephone Number:
Referrers location and profession:	Email address:
Date:	Signature:

For further information contact 0871800953