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 □ SALT □ 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 Yes □ No □ 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 info. 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 SF • 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 Yes □ No □ *Specialist Older Person Multi-Disciplinary Team including assessment by Nursing, Physiotherapy, and OT.*	
AMBULATORY OUTREACH TEAM	**CONTACT** corksouth.icpop@hse.ie **087 180 0953**
• Have acute care needs that can safely be managed at home Yes □ No □ • Requires Specialist Multidisciplinary Rehabilitation at home Yes □ No □	

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

For further information contact 087 180 0953