Integrated Care Services for Older People Referral Form
Incorporating:

RAPID ASSESSMENT CLINICS FOR MEMORY, FRAILTY, FALLS, MOVEMENT DISORDERS.

OUTREACH SUPPORT SERVICE

Name:

Address:

Male: ☐ **Female**: ☐ **D.O.B :**

Phone Number(s):

Contact Person:

Contact Details:

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 ☐ _____

MDT TEAM INVOLVED	CONTACT
WARD	
Medical Team	
Geriatrician	
CNM2	
PHYSIO	
Occupational Therapist	
Dietician	
Speech and language therapist	
Discharge Coordinator	

Presenting Complaint:

Mobility Status

Independent ☐ Use of aids: _____

Level of assistance required :_____

Cognitive Status

Orientated ☐ Confused ☐

4AT Score ☐ MMSE ☐ MOCA ☐

Reason for Referral and Intervention :

OUTREACH SUPPORT ☐

ASSESSMENT- Older people who require nursing and MDT assessment in their home ☐

REHAB- Older people who require a coordinated ambulatory rehabilitation program following a hospital admission ☐

SUPPORTIVE DISCHARGE-Older people post recent illness with a change of their baseline function ☐

CRISIS- Older persons with declining function who would benefit from MDT input to support hospital ☐

Goals for Outreach Intervention :

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

Level of Support:

Lives: Alone ☐ With Family ☐

Health Care Services Involved in the community:

PHN ☐ Name/Health Centre : _____

Home Help ☐ Meals on Wheels ☐

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

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

Infection Control Status; MRSA, C-Diff, VRE, COVID-19, Other?	**Known allergies, alcohol or drug addiction?**
Full Prescription supplied & discharge letter (please attach) YES ☐ NO ☐ YES ☐ NO ☐	**Communication deficits** YES ☐ NO ☐ If yes please give details :
Other Concerns or information you consider relevant (please specify):	

Please identify which service you wish to access:

RAPID ASSESSMENT SERVICE Multi-factorial assessment to prevent/avoid hospital attendance or admission: ● Falls ☐ ● Frailty ☐ ● Memory ☐ ● Movement Disorder ☐ ● Rapid Access review (< 2weeks) ☐ Cork South Hub SFH supporting Community Networks 4,5,6 (Mallow hub will support when operational) 10,11,12,13,14 Cork North Hub St.Mary's Health Campus supporting Community Networks 7, 8, 9.	**CONTACT:** corksouthcity.icpop@hse.ie CorkNorthCity.icpop@hse.ie
OUTREACH SUPPORT TEAM - 12KM radius from SFH ☐	**CONTACT** 0871800953 corksouthcity.icpop@hse.ie

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

For further information contact 0871800953