Single Point of Access Referral Form
Tel No : 01254 283631
Please fax to: 01254 283968
Email: bwdspa@lancashirecare.nhs.uk

NB: ***FORMS THAT ARE NOT FULLY COMPLETED WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE REFERRER***

Patient Forename:				
Patient Surname:				
House No/Street/Town:				
Postcode:				
Telephone Number:				
Date of Birth:				
Has patient consented to referral:	**Yes:** **No: (if no state reason)**			
GP Name & Surgery:				
NHS Number:		**Gender**	**Male** (please circle)	**Female** (please circle)

Next of Kin details (please complete)	
Next of Kin Forename:	
Next of Kin Surname:	
Next of Kin Address:	
Next of Kin Tel number:	

Reason for referral:

Diagnosis:

Services required: (please circle)

District Nurse

Community Stroke Team

Occupational Therapy

Pulmonary Rehabilitation

Intensive Home Support Service (IHSS)
- Rapid Assessment Team
- IV Therapy
- Complex case managers
- Acute COPD service
  (to refer to COPD please ring 01772 777042)

Integrated Neighbourhood Team

When service is required:

Any instructions re-access to the building e.g. (key with neighbour)

Any areas of risk for staff visiting: **Yes / No** (please circle)**If yes, give details**

Name of referrer:	**Location/Base of referrer:**
Designation of referrer:	**Referrer's contact number:**