Wirral Community NHS
NHS Trust

Community Nursing Referral Form

IF NOT COMPLETING ELECTRONICALLY PLEASE PRINT IN BLACK PEN			
PATIENT'S FULL NAME AND ADDRESS:		**NHS Number:**	
PHONE NUMBER:		**DATE OF BIRTH**	
MOBILE:			
GENERAL PRACTITIONER, ADDRESS AND TELEPHONE NO.			
Other Agencies Involved:			
Next of Kin/ Emergency contact No. (If known)			
If a key code is required please tick box PLEASE CONTACT REFERRER FOR DETAILS ☐		**PLEASE RECORD CURRENT MEDICATION BELOW OR <u>ATTACH PATIENT SUMMARY RECORD</u>**	
PAST MEDICAL HISTORY		**RISKS TO STAFF SAFETY IDENTIFIED**	
ALLERGIES:		**KNOWN INFECTION STATUS:**	
Reason for referral:			
ACUTE ASSESSMENT REQUIRED WITHIN 2 HOURS TO PREVENT HOSPITAL ADMISSION			
EXPECTED DATE OF FIRST CONTACT			
PMAC ATTACHED ☐ **YES** ☐ **NO**		**(PLEASE GIVE REASON BELOW)**	
MEDICATION SUPPLIED			
PRESCRIPTION SENT TO PHARMACY ☐ YES ☐ NO			
COMMUNICATION ISSUES:			
Language Preference (please state)		**Interpreter required?** ☐ YES ☐ NO	
Referrer Name and Designation:		**Referrer Signature:**	
Date	**Time:**	**REFERRER'S CONTACT NUMBER:**	