Cyrenians

OPAL Older People, Active Lives

Referral form

Please complete all sections of this form.

Section 1: Referrer Details			
Referrer's Name:		Referral date:	
Job Title:		Organisation	
Tel Number/s:			
Email:			

Section 2: Reason for Referral

- Loss of confidence ☐
- Living distant to family and friends ☐
- Recently bereaved ☐
- A change in abilities e.g. recent discharge from hospital ☐
- Suffering from low mood/anxiety ☐
- Would like to engage more with the local community ☐
- Other (please specify below) ☐

Other:

Section 3: Client Personal Information			
Full Name:		Date of Birth:	
Preferred name: *(e.g. Bill for William)*		Preferred Pronoun: *(please tick, or specify for 'other')*	she/her ☐ he/him ☐ they/them ☐ other
Address: *(including Post Code)*			
Home Tel Number		Mobile Number:	
Email:			
Emergency Contact details			
Full Name:		Date of Birth:	
Address: *(including Post Code)*			
Home Tel Number:		Mobile Number:	
Is the client aware that a referral is being made to OPAL? Yes ◯ No ◯			
Can we contact the client directly? Please select			

Section 4: Health Information

Mobility - Good ◯ Fair ◯ Poor ◯

Details of mobility *(e.g. able to walk a small distance, can't walk unaided, housebound, walks with a stick, uses a frame)*:

Physical health problems *(e.g. COPD, suffered a stroke, angina, diabetic)*:

Sensory

Any sight issues? (*e.g. wears glasses, glaucoma, macular degeneration, etc.):*

Any hearing issues? (*e.g. hearing aid worn, losing hearing but won't wear aid*):

Care Provider	**Day Care**	**CPN**
Name: Tel: How often:	Location/s: Days attends:	Name: Tel:

Mental Health

1. Does the client have early-stage Dementia/Alzheimer's **-** Yes ◯ No ◯
2. Does the client suffer from Low Mood/Depression/Anxiety - Yes ◯ No ◯
3. Is the client suffering from any other Mental Health conditions? (*e.g. bipolar, schizophrenia, borderline personality disorder – please list and provide information on how condition is managed*)

Are there any known risk factors? *(e.g. anger management issues, drug/alcohol dependency, pets in household, smoker)*

Please let us know what support your client currently has from professionals *(including support from you as the referrer and any others e.g. Support Worker, Occupational Therapist, Psychologist, Physio, attends classes or therapy, etc.)*

Please let us know what support your client currently has from family and friends *(e.g. meets sister once a week, lives with parents, lunches with friend weekly, attends local group)*

Section 5: Service Required

What support do you think would be suitable for this client?
(please tick all that are appropriate)

One-to-one support ☐

Telephone support ☐

Accompanied/introduced to local group by volunteer ☐

What would the person you are referring like to do? What interests do they have?

Is there any other information you would like to include?

It is our policy to liaise with the referring agency during the service period. Please keep us informed of any changes to the client's situation. A Coordinator will assess this referral and then contact the client or client's representative to book an initial assessment.

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You can contact us on: **Email** – opal@cyrenians.scot **Tel** – 01506 815 815