 **WELFARE REFERRAL FORM**

Please email referrals to [necmid.sbh.welfare@nhs.net](mailto:necmid.sbh.welfare@nhs.net)

|  |  |
| --- | --- |
| **Patient Details** | |
| Full Name |  |
| Date of Birth |  |
| Home Address |  |
| Postcode |  |
| Telephone number(s) |  |
| NHS Number |  |
|  |  |

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| **Patient must be registered with a Lincolnshire GP** | |
| GP Surgery address |  |

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| **Patient Information Needs** (\*delete as appropriate) | |
| 1. Is the patient aware of their diagnosis/Prognosis? 2. Has the patient agreed to referral to the Welfare Team? | Yes / No\*  Yes / No\* |

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| **Reason for Referral** |

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| --- | --- |
| **Medical Information** | |
| Current Diagnosis |  |
| Relevant past medical history |  |
| Prognosis |  |

|  |  |
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| **Referrer details** | |
| Name |  |
| Designation |  |
| Contact details |  |
| Date of referral |  |