 **WELFARE REFERRAL FORM**

Please email referrals to necmid.sbh.welfare@nhs.net

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| **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  |  |