PureCare

Referral Form

Date of Assessment: ___________________________

Assessment completed by: ____

❑ Personal history

Name: _______________________ Date Of Birth: _________________

Family Members: ____

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Religion: ________________________ Culture: _____________________

Background: ____

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Diagnosis: ____

❑ Medication History

Current Medication: ____

Time & Dose: ____

Current Medication: ____

Time & Dose: ____

Current Medication: ____

Time & Dose: ____

Past medication History:

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Allergies: ____

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- ❑ **Mental health** - support needs and details of potential risk to self or others

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Enclose any Risk Assessments

Behaviour: ____

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Enclose any behaviour plans

- ❑ 24-hour support requirements

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- ❑ Intimate and Personal support

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Please Return Completed Forms to:

Michelle Mitchell
Senior Manager
PureCare
109 Rock Avenue, Gillingham, Kent, ME7 5PY

E-mail michelle@purecareuk.com