Renfrewshire
Health & Social Care
Partnership

# A&E
# RES referral form

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|---|---|---|---|
| **Patient Name/DOB/CHI:** *Affix Patient label here* | | | **GP Name/Surgery:** *Affix GP label here* |
| Address:<br><br>Lives alone: Yes/No | | | Tel No: |
| Access: | Key safe:<br>(number) | Door Entry | Does patient have their keys? Yes/No<br>If No: how is access gained?<br>Name & address of key holder: |
| Next of kin/ carer details:<br><br>Relationship to patient: | | | Tel No: |

| | | | |
|---|---|---|---|
| Referrer name: | Referrer designation: | | EDD: |
| A&E ☐<br>Fracture Clinic ☐ | Referrer Tel No: | Time of arrival in dept: | |

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|---|---|---|---|
| Patient consent to referral to RES: | | Yes/ No | |
| Date of referral | | Date of assessment | |
| Time of referral | | Time of assessment | |

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| Current Diagnosis/reason for admission to Dept: / Past Medical History *(include allergies)* |
| Reason for Referral to RES: |
| **Mobility and Functional Status: (e.g. walking aids etc)** |

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|---|---|---|---|
| **Referral details recorded by:** | **Name:** | **Date:** | **Time:** |
| | **Designation:** | | |