

The Sussex Beacon Referral Form

Please complete and push the Submit button on the final page.

PLEASE SEND COPIES OF RECENT CLINICAL CORRESPONDENCE BY FAX to **01273 819151**



Client Details			
Surname:	Male Female	Age:	Client consent to contact: Yes No
First Name:	Date of Birth: dd/mm/yyyy		Is GP aware of referral? Yes No
Address:			Has Client been referred previously? Yes No
Post Code:			Contact Tel:
Marital Status:			Nationality:

Referrer's Details	General Practitioner	Next of Kin
Name:	Name:	Name:
Address:	Address:	Address:
Post Code:	Post Code:	Post Code:
Tel:	Tel:	Tel:
Email:	Fax:	Mob:
Position Held:	Aware of Status?: Yes No	Relationship:
Referral Date:		Aware of Status?: Yes No

HIV Consultant:	Email:
HIV Clinic and Address:	Tel:
Post Code:	Dr
HAS ADDITIONAL MEDICAL SUMMARY BEEN PROVIDED? YES NO	Date:

Other Health Professionals involved in care		
Name:	Position / Role:	Contact No.:

THIS INFORMATION IS CONSIDERED PRIVATE AND CONFIDENTIAL

Type of Care Required	
Adherence / Treatment Support	Medical Convalescence / Rehabilitation
Palliative / End of Life Care	Monitoring / Maintenance of Health
High Dependency Respite	Low Dependency Respite

Brief History of Diagnosis / Key Treatments / Events				
Date	Disease progression / Investigation/ Procedure			Ongoing Y/N
dd/mm/yyyy	CD4:	%:	V/L:	
				Y N
				Y N
				Y N
				Y N
				Y N

Current Health Issues (including Psychological, Social or Spiritual issues)	
1.	4.
2.	5.
3.	6.
Does Client Smoke? Yes No	If Yes would they like information or support in stopping? Yes No

Please List Current Medications	
	Cont.
Does client self administer medications? Yes No	Who supplies Medications:
Does client use: Dosett Box Blister Packs	

Alcohol and Drugs Policy	
Has the client used non prescribed drugs in past 12 months? No Yes	Please Elaborate if Yes:
Do you or the client anticipate any problems adhering to The Sussex Beacon drugs policy?	YES NO
Do you or the client anticipate any problems adhering to The Sussex Beacon alcohol policy	YES NO
Would client be willing to attend a pre admission assessment if requested	YES NO

Funding	
Has Funding been confirmed? Yes No	How Long for?:
By Whom:	Contact Details: