HOOP
Keeping you in the loop

RBH
ALL TOGETHER BETTER LIVING

# HOOP: HOUSING OPTIONS FOR OLDER PEOPLE REFERRAL FORM

| Person(s) being referred | | | |
|---|---|---|---|
| **Main Applicant:** | **Title:** 6 **First Name(s):**<br>**Last Name:** | **D.O.B.** | |
| **Secondary Applicant:** | **Title:** 6 **First Name(s):**<br>**Last Name:** | **D.O.B.** | |

| Main Applicant Details | | | |
|---|---|---|---|
| **Address:** | **House Number/Street:**<br>**Town:**<br>**County:** **Postcode:**<br>**Property tenure:** 28 **Property type:** 10 | | |
| **Lives alone:** | N | **Start date of tenancy:** | |
| **Telephone:** | | **Rehousing Application Number:** | |
| **Mobile:** | | **NI Number:** | |
| **Email:** | | | |

## Reason(s) for referral

☐ Rehousing ☐ Health/Wellbeing ☐ Financial ☐ Social Isolation ☐ Mobility ☐ Aids/Adaptations

## Any known risks

☐ Drug/Alcohol abuse ☐ Dog ☐ Do not visit alone ☐ Mental health

☐ Language difficulties ☐ Bedridden ☐ Inappropriate behaviours ☐ Aggressive behaviours

| Referrer details | CLIENT_CONTACT_TYPE.37 | | |
|---|---|---|---|
| **Contact Name:** | | **Job title:** | |
| **Organisation:** | | **Team:** | |
| **Telephone:** | | **Mobile:** | |
| **Email:** | | **Referral date:** | |

| Next of kin details | | | |
|---|---|---|---|
| **Name:** | **Title:** **First name(s):** **Last Name:** | | |
| **Relationship:** | 23 | **Telephone no:** | |
| **Address:** | **Street/Road:** **Town:** **County:** **Postcode:** | | |

| Contact details (carers): | | | | |
|---|---|---|---|---|
| **Home Care Agency:** | | | **Telephone:** | |
| **Days** | Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ | Seven days a week ☐ | **Visiting Times:** | |

| GP details | | | |
|---|---|---|---|
| **Name of GP:** | | **Telephone:** | |
| **Email:** | | | |
| **Address:** | **Street/Road:** **Town:** **County:** **Postcode:** | | |

| Social Worker | | | |
|---|---|---|---|
| **Name:** | | **Telephone:** | |
| **Email:** | | | |
| **OT** | | | |
| **Name:** | | **Telephone:** | |
| **Email:** | | | |
| **Support Planner** | | | |
| **Name:** | | **Telephone:** | |
| **Email:** | | | |
| **Other agencies/support (please state)** | | | |
| **#1 Name:** | | | |
| **Type:** | CLIENT_CONTACT_TYPE.38 | **Telephone:** | |
| **Email:** | | | |
| **#2 Name:** | | | |
| **Type:** | CLIENT_CONTACT_TYPE.38 | **Telephone:** | |
| **Email:** | | | |
| **#3 Name:** | | | |
| **Type:** | CLIENT_CONTACT_TYPE.38 | **Telephone:** | |
| **Email:** | | | |

| Services | |
|---|---|
| **Do you have RBH response?** N | **Do you have careline?** N |

| Medical information | | | |
|---|---|---|---|
| **Dementia:** | ☐ Yes ☐ No | **Parkinson's:** | ☐ Yes ☐ No |
| **Angina:** | ☐ Yes ☐ No | **History of Stroke:** | ☐ Yes ☐ No |
| **History of Heart Problems:** | ☐ Yes ☐ No | **Pace Maker fitted:** | ☐ Yes ☐ No |
| **Asthma:** | ☐ Yes ☐ No | **Epilepsy:** | ☐ Yes ☐ No |
| **COPD:** | ☐ Yes ☐ No | **Deaf:** | 3 |
| **Blind:** | 3 | **Wheelchair user:** | ☐ Yes ☐ No |
| **Diabetes:** | 4 | **Prone to falls?** | ☐ Yes ☐ No |

**Additional information:**

**All referrals should be emailed to: hoop@rbh.org.uk**